Lessons Learned 2000

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

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CityMatCH

From the 2000 CityMatCH Urban MCH Leadership Conference: Many Trails, One Destination

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Lessons Learned 2000:

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

From the City**Mat**CH
Urban MCH Leadership Conference
Westminster, Colorado
September 2000

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City**Mat**CH is a national organization of urban maternal and child health programs and leaders. City**Mat**CH was initiated in 1988 to address the need for increased communication and collaboration among urban maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. City**Mat**CH, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. City**Mat**CH also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States.

For more information about City**Mat**CH, contact Dr. Magda Peck, City**Mat**CH Executive Director/CEO, Department of Pediatrics, University of Nebraska Medical Center, 982170 Nebraska Medical Center, Omaha, NE 68198-2170, Phone: (402) 595-1700 or visit us at our website http://www.citymatch.org.

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Acknowledgements

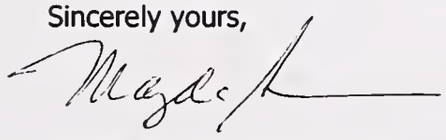
Lessons Learned 2000: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health is the fourth in the publication series from City**Mat**CH, the national organization of urban maternal and child health (MCH) programs and their designated MCH leaders in local health departments serving America's cities. The intent of this compendium is to facilitate easy access to selected urban public health practices aimed at improving the health of women, children and families. It serves to promote communication across communities about what works, what doesn't work and why, with the understanding that readers have the capacity and responsibility for following up on initiatives of interest.

Many of the urban MCH initiatives have not been evaluated formally; their utility to readers lies in the initial research and troubleshooting that has been done. The profiles serve as a springboard for the development or enhancement of future local, urban health projects. Each of the City**Mat**CH member health departments attending the September 2000 Urban MCH Leadership Conference submitted a profile of a current MCH effort as part of their active participation.

Every health department submitting an urban MCH profile deserves special recognition for passing on valuable lessons learned and for trying to impact the health of children and their families in urban communities. Conference co-chairs Betty Thompson (Nashville, TN) and Linda Welsh (Austin, TX) are to be commended for having navigated a very successful conference experience. City**Mat**CH staff – Diana Fisaga, Maureen Fitzgerald, Phillip Jones, Kelly McIntosh, Joan Rostermundt, and Patrick Simpson – deserve kudos for their hard work in producing a user-friendly tool for broader use. Final thanks to the Maternal and Child Health Bureau, HRSA, for providing essential funding to allow City**Mat**CH to continue to serve as a partner for information and communication.

We hope *Lessons Learned 2000* can be a spark to ignite action and change for urban health departments striving to improve the health and lives of women, children and families. Please let us know if, and how this tool has provided help and guidance.

Sincerely yours,



Magda G. Peck, ScD
CEO/Executive Director, City**Mat**CH

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Weighing In: What Lessons Have We Learned?

History of "The Book" - The mission of City**Mat**CH, the nationally recognized membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States, is to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. Serving as a national resource center for data, policy, and capacity building on urban maternal and child health, CityMatCH offers a collegial support system for those who seek to improve and enhance MCH practices and policies at the local, state, and national level. To that end, in 1996, City**Mat**CH first responded to the call for "best practices" and "models that work" and developed a new publication series, *"Lessons Learned: Profiles of Urban Health Department Initiatives in Maternal and Child Health."* Each urban health department codes its profile according to these indexes prior to submission.

How We Get these Profiles and Why - The 11th Annual Urban MCH Leadership Conference was held in Westminster, Colorado in September, 2000, bringing together the designated maternal and child health leaders from over seventy urban city and/or county health departments. These leaders, representing health departments in major urban areas, whose jurisdictions include one or more cities, with populations of 100,000 or greater, each submitted a "profile" of an urban MCH effort as a requisite for their federally subsidized attendance. Profiles submitted responded to a series of questions which describe the effort, the budget and funding, expected outcomes, evaluations planned, accomplishments, barriers, unexpected challenges, key partners and lessons learned.

How They Are Reviewed - Every profile submitted for inclusion has been edited, updated, reviewed and indexed in this edition of *Lessons Learned 2000*. From the submitted profiles, City**Mat**CH extracted data to create two profile indexes. The first lists the profiles Urban Health MCH by Type of Initiative; the second, describes these efforts by the Essential MCH functions, as described by Grason and Guyer in *"Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America."*

Summary of the Themes - Each year, the final question asked on the profile read something like this: ***"What is the greatest lesson your health department has learned and can share with others about this activity?"*** For five years, City**Mat**CH has followed and tracked the emerging themes, finding a pattern of three categories: planning; capacity building – including resources, funding, staff, and data; communications and collaborations with community and other agencies.

Themes

1 Local public health agencies are a critical component of the collaborative community effort that is needed to improve the health of children and families in urban areas.

City**Mat**CH strives organizationally to promote communication and collaboration to improve the health of urban children and families. Collaborations are often developed between or within member health departments, however this collaborative spirit also manifests itself in local urban health departments' decisions to join with external community partners. Knox County Health Department in Knoxville (TN) initiated and implemented 'Quick WIC' in January of 2000, providing services to groups of low-risk participants, thereby reducing waiting time for WIC services, and increasing participant utilization of the nutrition education center, and show rates

for appointments. They feel that, *"successful implementation of Quick WIC requires a collaborative effort among staff, supervisors, and administration with agencies within the community to offer a successful program that benefits all who are involved."* Knox County Health Department has been a catalyst for providing appropriate services to an underprivileged group of urban mothers and children. Hawaii State Department of Health in Honolulu provides critical oversight and staff support for the Hawaii Childrens' Trust Fund, a permanent endowment fund that provides grants to strengthen families, prevent child abuse and neglect, and promote the healthy development of children. The Health Department writes, *"neither public or private sector can do it alone – child abuse and neglect is a community issue that demands community involvement."* The leadership and direction the health department provides is critical to programmatic success.

2 Essential community support for urban MCH efforts is heavily dependent upon education, awareness and involvement in the process.

Berkeley (CA) Public Health Department's *Prenatal through Preschool Healthy Child Initiative* began in the Office of the Mayor, was transferred to the health department (Maternal, Child Health), and intersects with nearly every Berkeley community. According to the health department, *"relationships with public officials need to be constantly developed. Updates are critical; communication with all partners in the Initiative is also very essential. Nobody wants to be left out in decision-making."* Peoria (IL) City/County Health Department developed a community-wide program to assist families to successfully obtain health insurance under Illinois' SCHIP called KidCare. They discovered that *"building strong community support allowed the health department to function in a well-coordinated collaborative environment that provided the key to our success."* However, there can be serious roadblocks to gaining needed support. Madison (WI) Department of Public Health's Safe Nursery Action Group demonstrated an unfortunate reality: *"the priorities of health professionals and child advocates are not always shared by those who need to make the changes."* In those situations, education, awareness and involvement of key players throughout the process is critical to success. Of particular note is the statement made by Allegheny County Health Department, Pittsburgh (PA), *"Working closely in partnership with another entity was new for our partners and for us. The need for flexibility, diplomacy and patience was and is great." "In urban communities, it is critical that health departments form collaborative relationships with housing regulators and providers to address access to safe affordable housing,"* noted Providence (RI) Mayor's Policy Office. In partnership with the Rhode Island Department of Health, a coalition of health, housing social service agencies was created to address the large number of houses with lead hazards and an epidemic of childhood lead poisoning.

The Division of Public Health Northern Services, serving Wilmington (DE), participated in the Wilmington Enterprise Community Health Benchmarking Task force, forming the original Steering Committee and guiding the task force. It wasn't always an easy proposition; in their words, *"coalitions and community-driven groups are very difficult to maintain and a very resource intensive way to generate work. The results are subtle and it takes a long time to see results."*

3 The best collaborations are carefully planned from the start.

Collaborations involving local urban health departments can be complicated. The most successful are collaborations that are well crafted, based on data, and thoroughly evaluated. The Office of Public Health/East Baton Rouge Health Unit, Baton Rouge (LA) concurred when they wrote, *"planning on the front end of a new project is essential for the project to work smoothly."* Seattle-King County (WA) Health Department partnered with Washington State's TANF program, called WorkFirst, to develop a program to identify and provide services to enable families to

attain self-sufficiency. They initiated the idea and participated in collaborations with community partners and other agencies to design, plan and implement this effort. *"Collaborative implementation of a new program requires extensive initial system development, along with buy-in from all of the stakeholders."* This hard work and planning at the front end of a project is a key component of effective programs. Kansas City's (MO) Health Department determined that *"early planning and coordination with school districts was a must"* when they developed a school-based immunization program to protect area 6th graders from contracting hepatitis B.

The role of Onondaga County Health Department, serving Syracuse (NY) in the Healthy Start Registry has been one of collaboration in all phases of strategic planning. They are actively involved in the empowerment of all Consortium and community members, and are spearheading ongoing, comprehensive evaluation in relation to the effectiveness of evidence-based interventions. They write, *"The lesson learned is the value of collaborative strategic planning within the health department and between the Health Department and area providers and community-based agencies."*

4 Build on small successes; safeguard quality.

Guilford County Health Department in Greensboro (NC) began its Statewide Vasectomy Project as a local effort when outreach staff saw a need for such a program. Seeking and obtaining funding from the State Health and Human Services Department, the one-county vasectomy project began in the late 1970's. Building on a solid path of success, the project expanded statewide, currently with 13 urology practices performing procedures on clients referred by Guilford County. Guilford County also trains staff across the state to do counseling and consent. As they put it, *"If quality services are made available, people will seek you out. If you run your program efficiently, physicians will seek you out to become providers."*

Fresno (CA) Department of Community Health, Fresno County Health Services Agency, was selected as one of six sites under the Weed and Seed/Safe Futures Nurse Home Visitation Initiative, to replicate the home visitation model developed by David Olds, PhD. Building on the success of his model, Fresno has gone on to demonstrate successful enrollment of very high risk pregnant women, low rates of program attrition and high mean rates of completed home visits. Local support continues, demonstrated by continued allocation of resources for the program. Jefferson County Department of Health and Environment in Golden (CO) developed a "Partners for Healthy Families" program, also following the model developed by Olds. The program, in early stages at the time of profiling, works to reduce the occurrence of infant impairments due to maternal use of alcohol and other drugs, reduce the number of reported incidents of child abuse and neglect, reduce the number of subsequent pregnancies to mothers, and reduce the amount of public assistance received by mothers.

5 Systems and behaviors <u>can</u> be changed - with much effort, persistence, commitment, motivation and time.

San Francisco (CA) Department of Public Health is the lead agency in the planning, implementation and evaluation of the Child Care Health Project. They discovered in working with other systems that *"trust must be created so that other disciplines understand that we want to work as a team in order to improve the health and well-being of the children."* Minneapolis (MN) Health and Family Support recognizes the challenge of sustainable system/behavior change - *"...maintaining is harder than initiating. Sustainability is better with all partners involved."*

Akron (OH) Health Department established a *Child Mortality and Morbidity Review Committee* to review all child deaths and near-deaths due to child abuse and neglect in Summit County, assess system performance and make recommendations for improvement of inner-agency and inter-agency performance, and to reduce the incidence of preventable deaths in Summit County. The

findings and analysis are then presented, along with recommendations for system improvement. They found that *"...trust and willingness to cooperate come slowly, but as they develop, system improvement can occur. Informed people can sincerely disagree, but they can still work together for a common purpose."*

"System/behavior changes require continuous support and information for all participants. Clear, ongoing and consistent communication is critical," wrote Seattle-King County's (WA) Health Department.

6 Good tools and good data are essential to the success of urban MCH initiatives.

Columbus (OH) Health Department described their efforts to improve the health and the health system for mothers and children through research and dissemination of information. In a collaborative venture with Ohio State University School of Medicine and Public Health, they have undertaken special research projects to understand the increasing Hispanic population. *"These (special research projects) helped our Department glean important information from these studies that we have not had time to do."* In addition to program data analysis, researchers spent time in clinics, recording observations and recommendations. With this unique set of information as a tool, appropriate interventions are more likely.

Indianapolis area hospitals conduct reviews of their fetal and infant deaths in partnership with the Indianapolis (IN) Healthy Babies Project of the Marion County Health Department, using NFIMR data abstraction forms. The objective of the activity is to look at the county's fetal and infant mortality and morbidity over a continual period of time, and determine what types of trends exist within the community, socially and professionally, that affect fetal and infant mortality. Having access to and utilizing the best tools to gain the appropriate data was a common thread among successful profiles of urban maternal and child health initiatives.

Boston's (MA) Public Health Commission introduced an Improving Birth Outcomes in Boston initiative. This initiative sought to improve birth outcomes, and to reduce racial disparities by improving the health status of women of child-bearing age by restructuring service delivery to women of childbearing age at community health centers and hospital outpatient departments. The Commission played a leadership role in project implementation, providing financial resources, staff support and data analysis, convening a citywide task force to oversee the development of project guidelines, policies and interventions. The health department found that *"it is possible to tackle a long-standing problem (racial disparities in infant mortality and low birth weight rates) in an innovative manner, with the appropriate use of data, and to garner support from key constituents."*

The City of Dallas (TX) Department of Environmental and Health Services reviewed findings from the Dallas County Child Death and Infant Mortality Review Team and found that 54% of Dallas County accidental deaths among children were a result of motor vehicle accidents. Using this finding, an assessment was conducted of all injury prevention activities within the department. This was followed up with a car seat observation survey at 5 WIC Clinics, where it was determined that over 80% of children were not properly restrained and that 38% did not have a car set. The Dallas Child Injury Prevention Program was created to increase child restraint compliance *"Baseline data on actual child restraint is now a known health indicator in the southwest Dallas service district."*

Summary

CityMatCH holds the philosophy that children and families in urban areas have unique needs and deserve special attention, and that these needs must be effectively addressed in order for all children, and ultimately our society, to achieve full potential. CityMatCH promotes learning opportunities that enable urban MCH leaders to improve their public health practice, problem solving, and leadership skills; and to serve as a collegial support system for those who seek to improve and enhance MCH practices and policies. Local health departments are a critical component of collaborative community efforts to better the health and well-being of children and families in urban areas. By creating awareness through education and involvement in the process, through the execution of carefully crafted plans, based on unique community needs, understood through the collection of appropriate data, and with the support and assistance of community partners, lives can be changed for the better. Welcome to Lessons Learned 2000: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health.

How to Use Profiles

What is a "profile"?

The annual City**M**at**CH** Urban Maternal and Child Health (MCH) Leadership Conference is a working meeting of invited urban MCH leaders representing member city and county health departments whose jurisdictions include one or more cities with populations of 100,000 or more (or the largest city in states not otherwise represented). A requirement of each invited health department is to submit a written profile of one of the health department's MCH initiatives from the past year.

The profile includes a description of objectives, activities, barriers faced and overcome, health department roles, funding, accomplishments, and lessons learned (see sample on page 6). The designated MCH representative to City**M**at**CH** may only receive federal subsidy for conference expenses if their profile is received prior to the Conference. Invited health departments are encouraged to submit a profile even if they are unable to send a representative to the Conference. Copies of profiles are included in the conference participant resource notebook to facilitate immediate peer exchange.

Why are "profiles" published?

Since 1992, in response to interest in and increasing demand for best practices in public health, City**M**at**CH** has edited and published urban MCH profiles as a core component of Conference Highlights. The profiles are published as a compendium of ideas to promote the exchange of information about perceived successful initiatives in urban MCH. City**M**at**CH** does not verify each profile, nor does it evaluate the initiative and efforts described. It is assumed that with the contact information provided, readers will follow up with the source health department to ask questions and secure essential additional information.

How are the "profiles" organized?

The profiles are presented in alphabetical order, by city and by state where the local health department is located. Each profile spans two pages, with standard headings boxed for easy reference. Contact information is listed at the beginning of each profile to allow direct follow up with the health department. The 72 city and county health departments submitting profiles for the 2000 Urban MCH Leadership Conference are listed on page 4. In 1993, City**M**at**CH** began to index the conference profiles using standard categories of MCH approaches and targeted MCH populations. This practice continues with the 2000 profiles. In addition, the 2000 profiles have been indexed by essential MCH program functions. Both Profiles Indexes, which appear on pages 10-21, are explained on the following page.

Using Profile Index I: Target Populations and Approaches

Profiles are listed in alphabetical order on the left margin, by city and by state where the health department is located. Each submitted urban MCH profile has been coded by City**Mat**CH staff for up to 49 categories of activity. Categories applying to a profile are shaded across the row corresponding to the health department's city/state. Population-specific activities appear on the left-hand page; systems-specific approaches are indexed on the right-hand page. To determine all categories within a given profile, read across both pages. To identify the range of initiatives within a given approach, read up and down.

Using Profile Index II: Essential MCH Program Functions

Profiles are listed in alphabetical order on the left margin, by state and by city where the health department is located. Using the "Ten Essential MCH Functions Framework" developed by a working group of public health organizations under the direction of the John Hopkins University Child and Adolescent Health Policy Center, each health department coded its profile for up to 49 categories of MCH functions. The full list of functions appears on the sample profile form on the following two pages. MCH function categories applying to each profile are shaded in Profile Index II. To determine all MCH functions within a given profile, read across both pages in the row for its city/state. To identify the range of initiatives within a given MCH function, read up and down the columns, which have been numbered on top to allow ease in reading the index vertically. These numbers also correspond to the MCH functions listed on the sample profile. More information about the MCH Functions Framework can be found in the publication, "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America", prepared by Holly Allen Grason, MA and Bernard Guyer, MD MPH at the John Hopkins University Child and Adolescent Health Policy Center, for HRSA/MCHB, AMCHP, ASTHO, City**Mat**CH, and NACCHO.

Comments and Feedback Welcome

City**Mat**CH needs feedback on how these profiles are used and how useful they are to public health practice. Tell us your comments and let us know of your experiences using the City**Mat**CH *Lessons Learned 2000* via E-mail: citymch@unmc.edu, or you may complete the evaluation form located at the back of this publication and return it to: City**Mat**CH, University of Nebraska Medical Center, Department of Pediatrics, 982170 Nebraska Medical Center, Omaha, NE 68198-2170.

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1. Assess and monitor maternal and child health status to identify and address problems.

2. Diagnose and investigate health problems and health hazards affecting women, children and youth.

3. Inform and educate the public and families about maternal and child health issues.

4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

7. Link women, children and youth to health and other community and family services and assure quality systems of care.

8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.

9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems.

Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Listing of Successful Leading Urban Health Department Initiatives in Maternal and Child Health

City**Mat**CH members attending the 2000 Urban MCH Leadership Conference were required to submit a profile outlining successful MCH initiatives. The profiles described objectives, partnerships, accomplishments, funding sources, barriers, and measures of success. The initiative did not have to involve direct service provision. A committee reviewed submitted profiles and presented a *Spot*Light award to those cities who created outstanding, innovative, and successful MCH initiatives. The 2000 *Spot*Light recipients are: Hartford, CT, Raleigh, NC, and St. Petersburg, FL.

Instructions for 2000 CityMatCH Member Urban MCH Profiles

Each year CityMatCH members are asked to profile a successful MCH effort in their community. This year you also have the option of submitting a 'pearl' — something that started out as an irritant but you worked on it until it was a thing of beauty! A pearl may be a hard-learned lesson or a bad idea that did some good after all.

Any recent innovative program, activity or lesson learned *not previously submitted* which has strengthened your capacity to serve children and families can be submitted. There will be three awards this year: Most Innovative, Most Replicable, and the Alchemy Award for turning lead into gold! *Activities do not have to be a program or involve direct service provision.* While you are welcome to attach additional documents, we ask that you use the attached form. Profiles will be provided to all conference participants and reproduced in the CityMatCH publication, "*Lessons Learned 2000: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health.*"

To receive financial assistance CityMatCH members must complete and submit a profile prior to or upon registration at the Conference.

Thank you for completing the 2000 Urban MCH Leadership Conference profile. If you have any questions or comments, please contact CityMatCH at the number listed below:

Please Mail, FAX or E-Mail Completed Profile by Friday, August 18 to:

CityMatCH at University of Nebraska Medical Center
Department of Pediatrics
982170 Nebraska Medical Center
Omaha, NE 68198-2170
Phone: (402) 595-1700 FAX: (402) 595-1683
E-Mail: CITYMCH@unmc.edu

Profiles received by Friday, August 18, 2000, will be included in conference materials & will be eligible for Spot*Lights* recognition. *Profiles must be typed. Handwritten submissions will not be accepted.*

Health Department: _____ City/State: _____
CityMatCH Representative: _____ Title: _____
Phone: (_____) _____ For more information contact: _____
(If other than CityMatCH Representative)

Activity Name: _____

Please consider my profile for (√ one): ☐ **Most Innovative** ☐ **Most Replicable** ☐ **Alchemy Award**

Please circle all "MCH Efforts*" that best apply to your "Activity," either Profile or Pearl.

Women's Health
1 Preconception promotion
2 Family planning
3 Breast/cervical cancer

Perinatal Health
4 Prenatal care
5 Expanding maternity services
6 Home visiting
7 Low birthweight/infant mortality
8 Substance abuse prevention
9 Breastfeeding/nutrition/WIC

Child Health
10 Immunization
11 Early intervention/zero to three
12 EPSDT/screenings
13 Expanded child health services
14 Injury (including child abuse)
15 Lead poisoning
16 Children with special needs
17 School-linked/based services

Adolescent Health
18 School-linked/based services
19 Violence prevention/at risk
20 Teen pregnancy
21 Teen parenting

Other
22 Communicable diseases
23 Family violence
24 Dental programs

Improving Access to Care for Urban Children & Families
25 Overcoming cultural barriers
26 Reducing transportation barriers
27 Expanding private sector links
28 Clergy & health connections
29 Schools & health connections
30 One-stop shopping locations
31 Mobile clinics for outreach
32 Other outreach activities
33 Increasing social support
34 Case coordination
35 Increasing access to Medicaid

Strengthening Urban Public Health Systems for MCH
36 Staff training
37 Strategic planning
38 Reshaping urban MCH
39 Securing MCH assistance
40 Managed care initiatives
41 Building coalitions & partnerships
42 Building MCH data capacity
43 Immunization tracking/recall
44 Infant/child death review

45 **Other** (please specify):
_____
_____
_____
_____
_____

* As used in "Lessons Learned 1998: Profiles of Urban Health Department MCH Efforts"

2000 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

Please circle all "MCH Functions*" that best apply to your "Activity," either Profile or Pearl.

Assess MCH Status

1 Develop tools standardizing data collection, analysis, reporting
2 Implement public MCH program client data systems
3 Analysis of demographics, economic status, behaviors, health status
4 Community perceptions of health problems/needs

Diagnose/Investigate Occurrence of Problems & Hazards

5 Tracking systems
6 Population surveys (BRFS, PRAMS, PedNSS, YRBS)
7 Environmental assessments
8 Maternal, fetal/infant, child death reviews

Promoting Positive Beliefs, Attitudes, Behaviors

9 Hotlines, print materials, media campaigns
10 Culturally appropriate health education materials/programs
11 Implement/support education services for special MCH problems
12 Assessment of provider reports regarding process and outcomes

Community Partnerships

13 Prepare, publish & distribute reports
14 Public advocacy for legislation & resources

Research/Demonstration Projects

15 Special studies
16 Development of models

Assess Community Priorities & Action Plans

17 Develop & promote MCH agenda & YR2000 National Objectives
18 Newsletters, convening focus groups, advisory committees, networks
19 Promote compatible, integrated service system initiatives

Promote, Enforce Laws, Regulations, Standards, Contracts (LRSC)

20 Consistent, coordinated policies across programs
21 MCH input in legislative base for health plans & standards
22 MCH legislative activity
23 Development, promulgation, review, updating LRSC
24 Certification & monitoring provider compliance
25 Professional license & certification process
26 Monitor MCO marketing practices
27 Ombudsman services

Assure Capacity/Competency of Public Health Work Force

28 Provide infrastructure/capacity for MCH functions
29 Staff training
30 Support of continuing education
31 Support of health plans/provider networks
32 Health care labor force analysis
33 Laboratory capacity

Link MCAH Population to Services

34 Provide outreach services
35 Transportation & other access-enabling services
36 Referral systems, resource directories, advertising, enrollment assistance
37 Monitor enrollment practices for ease of use
38 Identify high-risk/hard-to-reach populations & methods to serve them
39 Provide, arrange, administer direct services
40 Universal newborn screening programs
41 Detention settings, foster care, mental health facilities
42 Prior authorization for out-of-plan specialty services
43 Review process for ped LT care admissions, CSHCN home services
44 Managed Care model contracts & access issues
45 Pediatric risk adjustment methods & payment mechanisms
46 Identify alternative resources to expand system capacity

Evaluate Effectiveness, Accessibility, & Quality of MCH Services

47 Comparative analysis of HC delivery systems
48 Profiles of provider attitudes, knowledge & practices
49 Identify & report access barriers

50 Other (please specify):

_____
_____
_____
_____

* Source: Grason, H. And Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

2000 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

Please describe the activity:

Please describe the activity's objectives (specific, measurable):

Greatest barrier(s) facing implementation:

How are these barriers being overcome?

2000 CityMatCH Urban MCH Profile

Activity Name: _____ Health Dept: _____

Contact: _____ City/State: _____

How is the activity funded?

- ❑ City/County/Local government funds
- ❑ General state funds
- ❑ MCH block grant funds
- ❑ SPRANS funds
- ❑ Private source(s): Please specify:

_____

_____

- ❑ 330 funds
- ❑ Other Federal funds
- ❑ Third party reimbursement (Medicaid, insurance)
- ❑ Other: Please specify:

_____

_____

Approximate annual budget $_____

In planning, implementing and evaluating this activity, what has been the role of your health department?

Has this activity been formally evaluated?

- ❑ Yes
- ❑ No
- ❑ Don't Know

Has this activity been replicated elsewhere?

- ❑ Yes
- ❑ No
- ❑ Don't Know

What are the major accomplishments to date?

What are the lessons learned?

2000 Urban Health Department MCH Efforts

By type of initiative

Profile Index I

Target MCH Populations

		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
	Page	Preconception Promotion	Family Planning	Breast/Cervical Cancer	Prenatal Care	Expanding Maternity Services	Home Visiting	Low Birth Weight/Infant Mortality	Substance Abuse Prevention	Breastfeeding/Nutrition/WIC	Immunization	Early Intervention/Zero to Three	EPSDT/Screenings	Expanded Child Health Services	Injury (including child abuse)	Lead Poisoning	Children With Special Needs	School-Linked/Based Services	School-Linked/Based Programs	Violence Prevention/At-Risk	Teen Pregnancy	Teen Parenting	Communicable Diseases	Family Violence	Dental Programs
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Akron, OH	24														■										
Albuquerque, NM	26																								
Austin, TX	28						■					■					■								
Baltimore	30										■	■	■			■	■						■		
Baton Rouge, LA	32				■	■				■	■											■			
Berkeley, CA	34							■	■	■	■	■	■		■	■	■								
Boise, ID	36		■							■	■														
Boston, MA	38	■	■		■			■																■	
Cheyenne, WY	40				■	■	■	■	■	■	■		■		■		■				■	■			
Chicago, IL	42																							■	
Columbus, OH	44																								
Dallas, TX	46														■										
Dayton, OH	48				■		■			■	■		■	■					■						
Denver, CO	50													■				■	■						
Detroit, MI	52						■	■				■				■	■								
Durham, NC	54																	■							
El Paso, TX	56																								
Englewood, CO	58											■		■						■				■	
Evansville, IN	60			■																					
Fort Worth, TX	62																			■		■		■	
Fresno, CA	64	■	■		■		■	■	■	■	■	■			■						■	■			
Golden, CO	66						■	■				■			■						■	■		■	
Grand Rapids, MI	68							■	■								■								
Greensboro, NC	70		■																						
Hartford, CT	72						■									■									
Honolulu, HI	74														■					■					
Indianapolis, IN	76	■			■			■													■				
Kansas City, MO	78										■								■						

2000 Urban Health Department MCH Efforts

By type of initiative

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other –Child Care Parenting	Other –Self-efficacy Increasing	Other –Child Neglect/Abuse Prevention Link for Families	Other –Working with Private Pediatricians	Other –Private Health Care Provider Training & Support
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Akron, OH																	■								
Albuquerque, NM			■		■						■	■	■	■		■	■	■	■						
Austin, TX																					■				
Baltimore			■				■										■	■	■						
Baton Rouge, LA			■						■								■								
Berkeley, CA	■	■	■		■								■	■			■	■							
Boise, ID											■														
Boston, MA	■	■	■		■			■	■	■	■	■		■			■			■					
Cheyenne, WY																									
Chicago, IL																	■								
Columbus, OH																	■	■							
Dallas, TX																									
Dayton, OH										■	■					■	■								
Denver, CO					■								■				■	■							
Detroit, MI					■			■		■		■		■											
Durham, NC					■			■									■								
El Paso, TX						■																			
Englewood, CO			■		■				■			■		■											
Evansville, IN																									
Fort Worth, TX																									
Fresno, CA									■	■												■			
Golden, CO									■	■															
Grand Rapids, MI												■													
Greensboro, NC	■		■									■													
Hartford, CT					■								■	■			■	■							
Honolulu, HI	■		■										■				■								
Indianapolis, IN																	■	■		■					
Kansas City, MO					■	■		■							■				■						

2000 Urban Health Department MCH Efforts

By type of initiative

Profile Index I		Target MCH Approaches																								
		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
	Page	Preconception Promotion	Family Planning	Breast/Cervical Cancer	Prenatal Care	Expanding Maternity Services	Home Visiting	Low Birth Weight/Infant Mortality	Substance Abuse Prevention	Breastfeeding/Nutrition/WIC	Immunization	Early Intervention/Zero to Three	EPSDT/Screenings	Expanded Child Health Services	Injury (including child abuse)	Lead Poisoning	Children With Special Needs	School-Linked/Based Services	School-Linked/Based Programs	Violence Prevention/At-Risk	Teen Pregnancy	Teen Parenting	Communicable Diseases	Family Violence	Dental Programs
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Knoxville, TN	80									■															
Lexington, KY	82	■	■		■																				
Lincoln, NE	84				■		■																		
Little Rock, AR	86				■			■																	
Long Beach, CA	88	■	■		■						■		■												
Los Angeles, CA	90		■		■	■	■	■	■	■	■	■	■	■	■					■	■	■		■	
Louisville, KY	92	■	■				■				■	■	■		■					■	■	■		■	
Madison, WI	94														■										
Miami, FL	96											■	■	■		■									
Minneapolis, MN	98										■							■	■						
Missoula, MT	100		■				■			■							■	■			■	■		■	
Montgomery, AL	102	■				■	■											■		■	■				■
Nashville, TN	104											■		■			■	■							■
New Orleans, LA	106			■						■															
New York, NY	108																								
Norfolk, VA	110																							■	
Omaha, NE	112										■												■		
Orlando, FL	114																				■		■		
Peoria, IL	116																								■
Philadelphia, PA	118								■										■		■	■			
Phoenix, AZ	120									■															
Pittsburgh, PA	122													■											
Portland, ME	124							■	■																
Portland, OR	126																								
Providence, RI	128											■				■		■							
Raleigh, NC	130											■	■												
Rochester, NY	132													■				■							
Rockford, IL	134													■		■	■								

2000 Urban Health Department MCH Efforts

By type of initiative

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other –Child Care Parenting	Other –Self-efficacy Increasing	Other –Child Neglect/Abuse Prevention Link for Families	Other –Working with Private Pediatricians	Other –Private Health Care Provider Training & Support
City, State	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**
Knoxville, TN																									
Lexington, KY												■	■												
Lincoln, NE																		■							
Little Rock, AR																									
Long Beach, CA	■							■	■		■														
Los Angeles, CA	■	■	■					■	■	■	■	■					■								
Louisville, KY	■	■	■	■	■	■			■	■		■		■			■	■							
Madison, WI																	■								
Miami, FL																									
Minneapolis, MN	■				■				■		■														
Missoula, MT		■	■			■		■		■	■	■		■			■								
Montgomery, AL								■									■	■							
Nashville, TN		■			■	■	■			■							■								
New Orleans, LA	■			■				■	■								■								
New York, NY											■	■	■	■		■	■	■							
Norfolk, VA					■			■	■	■				■									■		
Omaha, NE																		■	■	■					
Orlando, FL								■				■					■								
Peoria, IL					■			■			■	■					■								
Philadelphia, PA					■			■									■								
Phoenix, AZ	■							■	■			■													
Pittsburgh, PA	■	■	■			■					■						■								
Portland, ME			■													■	■								
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Providence, RI	■				■	■		■		■							■	■							
Raleigh, NC														■			■							■	
Rochester, NY					■			■	■								■								
Rockford, IL						■		■																	

2000 Urban Health Department MCH Efforts

By type of initiative

Profile Index I

Target MCH Populations

		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
City, State	Page	1 Preconception Promotion	2 Family Planning	3 Breast/Cervical Cancer	4 Prenatal Care	5 Expanding Maternity Services	6 Home Visiting	7 Low Birth Weight/Infant Mortality	8 Substance Abuse Prevention	9 Breastfeeding/Nutrition/WIC	10 Immunization	11 Early Intervention/Zero to Three	12 EPSDT/Screenings	13 Expanded Child Health Services	14 Injury (including child abuse)	15 Lead Poisoning	16 Children With Special Needs	17 School-Linked/Based Services	18 School-Linked/Based Programs	19 Violence Prevention/At-Risk	20 Teen Pregnancy	21 Teen Parenting	22 Communicable Diseases	23 Family Violence	24 Dental Programs
Salem, OR	136				■		■	■									■				■				
Salt Lake City, UT	138																								■
San Antonio, TX	140	■																							
San Antonio, TX	142																	■	■						
San Diego, CA	144																			■					
San Francisco, CA	146											■		■	■		■								
Santa Ana, CA	148																								■
Santa Rosa, CA	150																								
Seattle, WA	152						■										■								
Spokane, WA	154																								
St. Paul, MN	156		■		■					■	■				■								■	■	
St. Petersburg, FL	158																								
Syracuse, NY	160		■		■		■	■	■	■		■		■		■	■		■	■	■	■	■	■	
Tucson, AZ	162																								
Waco, TX	164																								
Washington, DC	166					■	■			■	■						■								
Wayne, MI	168															■									
Wilmington, DE	170																								
Winston-Salem, NC	172	■	■		■	■		■													■	■		■	

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
2000 Urban Health Department MCH Efforts By type of initiative	Overcoming Cultural Barriers	Reducing Transportation Barriers	Expanding Private Sector Links	Clergy and Health Connections	Schools and Health Connections	One-Stop Shopping Locations	Mobile Clinics for Outreach	Other Outreach Activities	Increasing Social Support	Case Coordination	Increasing Access to Medicaid	Staff Training	Strategic Planning	Reshaping Urban MCH	Securing MCH Assistance	Managed Care Initiatives	Building Coalitions and Partnerships	Building MCH Data Capacity	Immunization Tracking/Recall	Infant/Child Death Review	Other –Child Care Parenting	Other –Self-efficacy Increasing	Other –Child Neglect/Abuse Prevention Link for Families	Other –Working with Private Pediatricians	Other –Private Health Care Provider Training & Support
City, State	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**
Salem, OR																									
Salt Lake City, UT						■					■														
San Antonio, TX												■					■								
San Antonio, TX					■							■		■			■								
San Diego, CA								■			■														■
San Francisco, CA												■					■								
Santa Ana, CA																	■	■							
Santa Rosa, CA								■																	
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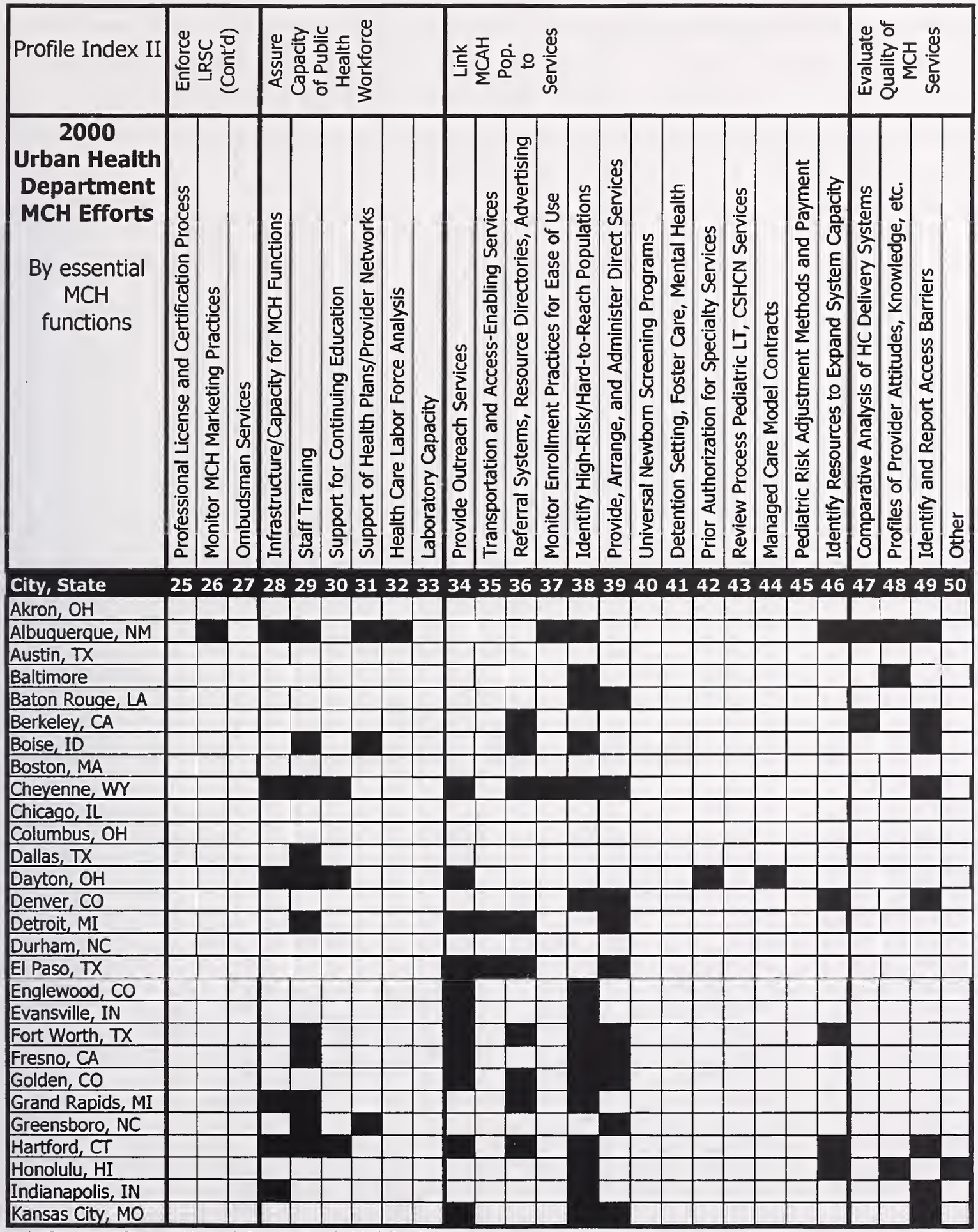
Spokane, WA	■																■								
St. Paul, MN	■								■		■						■								
St. Petersburg, FL	■		■					■				■													
Syracuse, NY	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■		■					
Tucson, AZ																									
Waco, TX					■												■								
Washington, DC	■										■														
Wayne, MI																									
Wilmington, DE																	■								
Winston-Salem, NC	■	■	■					■	■				■				■								

Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promoting Positive Attitudes and Behaviors				Comm. Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
2000 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**
Akron, OH	24	■							■					■	■										
Albuquerque, NM	26	■	■	■	■	■						■	■	■	■					■	■	■			■
Austin, TX	28			■										■	■				■						
Baltimore	30	■	■	■		■								■				■			■				■
Baton Rouge, LA	32																■			■					
Berkeley, CA	34	■		■	■		■	■		■				■	■				■	■					
Boise, ID	36																			■					
Boston, MA	38																								
Cheyenne, WY	40	■	■	■	■					■		■		■	■					■	■		■		
Chicago, IL	44																								
Columbus, OH	42	■		■										■		■									
Dallas, TX	46	■				■												■							
Dayton, OH	48			■	■					■									■						
Denver, CO	50	■		■	■									■	■					■					
Detroit, MI	52											■					■			■					
Durham, NC	54	■						■		■	■			■					■						
El Paso, TX	56																		■	■					
Englewood, CO	58								■	■		■													
Evansville, IN	60											■													
Fort Worth, TX	62									■	■	■							■						
Fresno, CA	64			■	■											■									
Golden, CO	66							■							■										
Grand Rapids, MI	68											■													
Greensboro, NC	72			■						■	■	■	■												■
Hartford, CT	74	■		■	■	■	■	■		■			■	■	■		■			■	■	■	■		
Honolulu, HI	76				■									■	■				■	■					
Indianapolis, IN	78	■		■		■			■					■				■	■						
Kansas City, MO	80									■	■			■						■				■	

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD



* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promote Positive Attitudes and Behaviors				Comm. Partners		Research /Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
2000 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Knoxville, TN	82										■									■					
Lexington, KY	84	■							■		■	■	■	■				■							
Lincoln, NE	86	■		■																	■				
Little Rock, AR	88	■				■			■	■										■					
Long Beach, CA	90										■	■													
Los Angeles, CA	92		■			■					■	■													
Louisville, KY	94		■	■		■					■	■	■		■			■		■					
Madison, WI	96									■		■			■										
Miami, FL	98	■																							
Minneapolis, MN	100									■	■														
Missoula, MT	102	■	■		■			■		■	■	■			■			■	■	■			■		
Montgomery, AL	104	■		■	■						■	■					■	■							
Nashville, TN	106	■	■	■		■														■					
New Orleans, LA	108				■					■	■														
New York, NY	110				■		■			■	■			■	■	■		■			■	■			
Norfolk, VA	112	■															■								
Omaha, NE	114	■	■																						
Orlando, FL	116	■								■	■	■					■		■						
Peoria, IL	118									■				■	■				■	■					
Philadelphia, PA	120									■	■	■													
Phoenix, AZ	122	■			■	■		■				■		■			■								
Pittsburgh, PA	124														■		■								
Portland, ME	126			■	■											■									
Portland, OR	128																								
Providence, RI	130	■		■				■																	
Raleigh, NC	132																■								
Rochester, NY	134											■					■								
Rockford, IL	136							■												■					

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II	Enforce LRSC (Cont'd)			Assure Capacity of Public Health Workforce							Link MCAH Pop. to Services														Evaluate Quality of MCH Services			
2000 Urban Health Department MCH Efforts By essential MCH functions	Professional License and Certification Process	Monitor MCH Marketing Practices	Ombudsman Services	Infrastructure/Capacity for MCH Functions	Staff Training	Support for Continuing Education	Support of Health Plans/Provider Networks	Health Care Labor Force Analysis	Laboratory Capacity		Provide Outreach Services	Transportation and Access-Enabling Services	Referral Systems, Resource Directories, Advertising	Monitor Enrollment Practices for Ease of Use	Identify High-Risk/Hard-to-Reach Populations	Provide, Arrange, and Administer Direct Services	Universal Newborn Screening Programs	Detention Setting, Foster Care, Mental Health	Prior Authorization for Specialty Services	Review Process Pediatric LT, CSHCN Services	Managed Care Model Contracts	Pediatric Risk Adjustment Methods and Payment	Identify Resources to Expand System Capacity	Comparative Analysis of HC Delivery Systems	Profiles of Provider Attitudes, Knowledge, etc.	Identify and Report Access Barriers	Other
City, State	25	26	27	28	29	30	31	32	33		34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Knoxville, TN																■											
Lexington, KY					■											■											
Lincoln, NE															■												
Little Rock, AR																										■	
Long Beach, CA											■		■		■												
Los Angeles, CA					■						■	■			■	■											
Louisville, KY				■	■	■						■	■		■								■			■	
Madison, WI																											
Miami, FL																											
Minneapolis, MN															■												
Missoula, MT				■	■	■	■				■		■		■	■	■			■			■			■	
Montgomery, AL				■	■						■	■			■	■							■	■			
Nashville, TN											■		■		■	■										■	
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New York, NY				■									■								■		■				
Norfolk, VA											■				■	■										■	
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Orlando, FL					■						■																
Peoria, IL				■	■		■						■	■	■								■			■	
Philadelphia, PA											■																
Phoenix, AZ					■								■	■													
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Portland, ME															■										■	■	
Portland, OR																											
Providence, RI																											■
Raleigh, NC							■								■								■				
Rochester, NY															■	■											
Rockford, IL											■				■	■											

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Profile Index II		Assess MCH Status				Diagnose Problems and Hazards				Promoting Positive Attitudes and Behaviors				Comm. Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
2000 Urban Health Department MCH Efforts By essential MCH functions	Page	Tools for Data Collection, Analysis, Reporting	MCH Program Client Systems	Analysis of Demographics, Health Systems, etc.	Community Perceptions of Health Problems	Tracking Systems	Population Surveys	Environmental Assessment	Maternal, Fetal/Infant Child Death Reviews	Hotlines, Print Materials, Media Campaigns	Culturally Appropriate Health Education	Services for Special MCH Problems	Assess Provider Reports on Outcomes	Prepare, Publish, and Distribute Reports	Public Advocacy for Legislation and Resources	Special Studies	Development of Models	Promote MCH Agenda/Year 2000 Objectives	Newsletters, Focus Groups, Advisory Comm.	Integrated Service Systems Initiatives	Consistent, Coordinated Policies	MCH Input in Legislative Base for Health Plans	MCH Legislative Activity	Develop, Promulgate, Review, Update LRSC	Certification, Monitoring Provider Compliance
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Salem, OR	138				■						■								■						
Salt Lake City, UT	140																			■					
San Antonio, TX	142				■					■	■			■			■	■	■		■				
San Antonio, TX	144	■		■	■					■	■			■			■	■	■						
San Diego, CA	146																								
San Francisco, CA	148				■																				
Santa Ana, CA	150	■														■	■								
Santa Rosa, CA	152																								
Seattle, WA	154											■													
Spokane, WA	156																								
St. Paul, MN	158										■														
St. Petersburg, FL	160					■				■	■	■						■			■				
Syracuse, NY	162	■	■	■	■	■			■	■	■	■	■	■	■		■	■	■	■	■	■	■		
Tucson, AZ	164																								
Waco, TX	166										■	■					■								
Washington, DC	168	■			■			■												■					
Wayne, MI	170						■																		
Wilmington, DE	172				■									■					■						
Winston-Salem, NC	174									■	■	■					■								

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II	Enforce LRSC (Cont'd)			Assure Capacity of Public Health Workforce						Link MCAH Pop. to Services												Evaluate Quality of MCH Services			
2000 Urban Health Department MCH Efforts By essential MCH functions	Professional License and Certification Process	Monitor MCH Marketing Practices	Ombudsman Services	Infrastructure/Capacity for MCH Functions	Staff Training	Support for Continuing Education	Support of Health Plans/Provider Networks	Health Care Labor Force Analysis	Laboratory Capacity	Provide Outreach Services	Transportation and Access-Enabling Services	Referral Systems, Resource Directories, Advertising	Monitor Enrollment Practices for Ease of Use	Identify High-Risk/Hard-to-Reach Populations	Provide, Arrange, and Administer Direct Services	Universal Newborn Screening Programs	Detention Setting, Foster Care, Mental Health	Prior Authorization for Specialty Services	Review Process Pediatric LT, CSHCN Services	Managed Care Model Contracts	Pediatric Risk Adjustment Methods and Payment	Identify Resources to Expand System Capacity	Comparative Analysis of HC Delivery Systems	Profiles of Provider Attitudes, Knowledge, etc.	Identify and Report Access Barriers	Other
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
Salem, OR										■				■	■											
Salt Lake City, UT										■				■	■											
San Antonio, TX				■	■					■															■	
San Antonio, TX				■	■	■	■			■														■		
San Diego, CA																										
San Francisco, CA																										■
Santa Ana, CA				■																						
Santa Rosa, CA																										■
Seattle, WA										■		■		■	■											
Spokane, WA																										■
St. Paul, MN														■	■											
St. Petersburg, FL				■	■					■		■	■		■			■								
Syracuse, NY				■	■	■					■	■	■		■					■					■	
Tucson, AZ										■				■	■											
Waco, TX																										
Washington, DC							■			■		■		■								■				
Wayne, MI														■												
Wilmington, DE																										
Winston-Salem, NC										■	■	■		■											■	

* Source: Grason H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

2000 Successful Urban Health Department Initiatives in Maternal and Child Health

Child Mortality Review Committee

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Maternal, fetal/infant, child death reviews Prepare, publish & distribute reports Public advocacy for legislation & resources	Injury (including child abuse) Building coalitions & partnerships

Funding Sources:
Other: Children's Services provides meeting space, staff support, and all other services, such as publishing reports

Budget: Not specified

Description:

Following the tragic and highly-publicized death of a child under the care of Children Services, a Child Mortality and Morbidity Review Committee was established in Summit County in 1991. A Subcommittee uses death certificates and medical examiner's reports to review the cases of all children under the age of 21, who die in Summit County. Situations involving potential "system issues" are referred for full review, and all involved agencies provide what they know about the case. Agency involvement may range from the EMT's who respond to the call of an injured or unresponsive child, to Children's Hospital, Children Services, and any other agency who may have been involved with the family (including WIC and the public health clinics). The full Committee often makes recommendations for system improvements (see below under accomplishments). A database of all deaths is maintained and reports are issued to the community periodically.

Objectives of the activity:

1. To review all child deaths and near-death incidents due to child abuse and neglect in Summit County, to assess system performance, to make recommendations for the improvement of inner agency and interagency performance, and to reduce the incidence of preventable deaths in Summit County. 2. To present through a designated spokesperson, a systematic statement of the Child Mortality and Morbidity Review Committee's analysis and findings, in order to assure the community that its interests are being represented, and 3. Promote cooperation and coordination between agencies involved in investigations of child death or in providing services to surviving family members.

Barriers encountered in implementation:	Strategies to overcome barriers:
Confidentiality issues. Timing—not wanting to interfere with ongoing investigations/prosecutions. Needing to be independent of Children Services and the rest of "the system". Difficulty including morbidity (near-deaths) in the process.	Legal counsel determined that the Committee did not fall under the state's "sunshine" law, so that discussion would not be public record, thus encouraging honest sharing. We delay full reviews during active investigations or prosecutions. We have community representatives, and Children Services officials have never served in leadership positions, although Children Services does not provide all staff services. We still have not overcome the challenge of incorporating serious injuries into our process.

Role of health department in implementation, planning, and evaluation:

The local health departments have been involved with the Committee since its inception. The health department representatives provide the death certificates that form the basis of the initial case reviews. The health department representatives serve as Chairperson of the Subcommittee for two years and full Committee Chairperson for two years.

Accomplishments:

"Red-flagging" system that alerts Children Services workers of previous deaths in the family. Improved communications and cooperation among the major agencies involved in child injuries and deaths, both within the Committee and in daily operations. Implementation of a protocol for Munchsuson Syndrome by Proxy. Enhanced prosecutions (Prosecutors did not know about WIC as a source of information). Comprehensive database of all children's deaths, allowing improved data analysis.

Lessons Learned:

Trust and willingness to cooperate come slowly, but as they develop, system improvement can occur. Informed people can sincerely disagree, but they can still work together for a common purpose. Community representation, even in limited numbers, can help us maintain a broader focus.

District 1 County Strategic Planning Process

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Implement public MCH Program client data systems Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Tracking Systems Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Prepare, publish & distribute reports Public advocacy for legislation & resources Promotes compatibile, integrated service system initiatives Consistent, coordinated policies across programs MCH input in legislative base for health plans & standards Certification & monitoring provider compliance Monitor MCO marketing practices Provide infrastructure/capacity for MCH functions Staff Training Support of health plans/provider networks Health care labor force analysis Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity Comparative analysis of HC delivery systems Profiles of provider attitudes, knowledge & practice Identify & report access barriers	Expanding private sector links Schools & health connections Increasing access to Medicaid Staff training Strategic planning Reshaping urban MCH Managed care initiatives Building coalitions & partnerships Building MCH data capacity Immunization tracking/recall

Funding Sources:
General state funds

Budget: Unknown

Description:

Bernalillo County, one of the seven counties of New Mexico's Public Health District I, has undergone a strategic planning process to adjust to reduced resources and to prioritize the public health activities of its five offices and approximately 80 employees. A multidisciplinary team has conducted the process in essentially seven steps: 1. compile a complete list of all activities; 2. for each activity determine the mandates, need, coverage by other providers, level of collaboration, and known effectiveness; 3. prioritize the activities based on the above; 4. assess the county public health resources; 5. allocate county public resources; 6. develop an action plan; 7. disseminate the action plan to the community and to policy makers. The planning process has necessarily focused on MCH issues as these constitute the bulk of our public health activities. The process has been heavily based on the ability to utilize hard data regarding the activities and their impacts. It was found, for example, that in 1999, 61% of children being vaccinated at public health offices were insured and could be going to their primary care providers.

Objectives of the activity:

The basic objective of the strategic planning process has been to make public health services more responsive to the core target population--the uninsured and the uninsurable. A collateral objective has been to assure that those eligible are signed up for Medicaid and learn to utilize their PCPs efficiently. Other objectives include increasing the capacity of our personnel to utilize data for decision making. Increasing public health's influence on the policies and practices of managed care organizations, and evaluating the roles of our multiple partnering efforts.

Barriers encountered in implementation:	Strategies to overcome barriers:
The need to train our own personnel in assessment skills was perhaps our greatest barrier. All planning was conducted by democratically chosen teams that might include anybody from clerks to program managers to MDs. Another barrier confronted was the limited access of our planning teams to those who can influence policy in MCOs.	Ongoing training in community assessment, data utilization, computer data skills, evaluation, and basic epidemiology are overcoming our main barrier to competent planning. It goes without saying that this training is helping in numerous other areas as well. The problem of access to MCO bosses was partially overcome by working closely with our partners (e.g., the County MCH Council, the Immunization Coalition, Turning Point.)

Role of health department in implementation, planning, and evaluation:

The County Offices of Public Health District I (with assistance from the district headquarters) were completely in charge of planning, implementing and evaluating this activity.

Accomplishments:

By working with our community partners, Bernalillo County Public Health Offices have managed to reduce the number of insured persons making inappropriate use of services by more than one-third in less than one year's time. In the same 12-month period, we also signed up approximately 1800 new Medicaid clients. More importantly, the schools and even some other providers are now actively enrolling families in Medicaid. This has helped to alleviate the immense workload of an understanffed and underfunded public health infrastructure. In addition, our public health staff has greatly increased its skills in utilization of data and partnering to achieve public health goals.

Lessons Learned:

The planning process relies on critical thinking and willingness to change on the part of public health staff--these things are not easy for all our staff. The concept of "indirect assurance" (convincing others to provide the services public health once provided) requires major retooling and great reliance on the development of effective partnership in order to make this a reality.

Early Education and Care Assessment

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Analysis of demographics, economic status, behaviors, health status Prepare, publish & distribute reports Public advocacy for legislation & resources Newsletters, convening focus groups, advisory committees, networks	Home visiting Early intervention/ZERO TO THREE Children with special needs Child care parenting

Funding Sources:
City/County/Local government funds

Budget: $10,000.00

Description:

Under the auspices of the Community Action Network (CAN), a collaborative planning and policy development body, the Austin/Travis HHSD Early Childhood Services and Travis County Planning and Assessment completed a community assessment of early education and care in our county. It focused on the current state of child care and parenting, and included recommendations on how to address needs and gaps in services. This report was a compilation of data and recommendations gathered by the Austin Child Care Council, Parent Leader Network and CAN Child Care Task Force. It was designed to give a comprehensive picture of our early education and care system.

Objectives of the activity:

Provide a profile of early education and care. Detail current services, funding levels and unmet needs for child care, special needs care and parenting. Present community recommendations to address unmet needs. Develop proposed community indicators for early education and care.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier to implementation was the number of entities involved and the difficulty in coordinating these partners. There were also time constraints and a lack of relevant data in key areas. While there is significant information available about child care, the information about special needs care and parenting was limited.	To implement the project, Travis County HHSD was named as the lead, so they coordinated the data collection and report writing. They worked hard to communicate. We will need to develop better data collection tools for more information about two areas.

Role of health department in implementation, planning, and evaluation:

Austin/Travis HHSD served as a key data source, reviewer and facilitator of various Task Force, focus groups and committees that provided input. Our Department was actively involved in all aspects of the assessment.

Accomplishments:

Assessment is completed and a report has been widely circulated in the community with a report to the Community Action Network. Increased city funding to address some needs identified in the assessment. Early Education and Care Planning Group meeting to develop an action plan to implement recommendations of the report.

Lessons Learned:

There is a need for a coordinated approach to data collection. In order to be effective, one must follow an assessment with specific action plans. It is difficult to present information in an easily understood way, but that is key to success.

Baltimore's Immunization Registry Program (BIRP)

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting	Immunizations
Implement public MCH Program client data systems	Early intervention/ZERO TO THREE
Analysis of demographics, economic status, behaviors, health status	EPSDT/screenings
Tracking Systems	Lead poisoning
Prepare, publish & distribute reports	Children with special needs
Consistent, coordinated policies across programs	Communicable diseases
Certification & monitoring provider compliance	Expanding private sector links
Identify high-risk/hard-to-reach populations & methods to serve them	Mobile Clinics for outreach
Profiles of healthcare provider attitudes, knowledge & practice	Building coalitions & partnerships
	Building MCH data capacity
	Immunization tracking/recall

Funding Sources:
Private source(s): Robert Wood Johnson Foundation, Annie E. Casey Foundation, Other Federal funds

Budget: $185,500 per year

Description:

Baltimore's Immunization Registry Program (BIRP) is a population-based RDMS that collects and securely re-discloses child identification, demographic locator and vaccination histories for under 6-year-old children receiving primary health care from medical providers in Baltimore City. BIRP reporting includes identification of individual children, families and neighborhoods at highest risk for delayed vaccination, as well as performance feedback to clinical practices. (NB: In Baltimore, vaccination coverage serves as an inferred measure to primary health care access.)

Objectives of the activity:

Integrate 100% of Baltimore's primary health care providers into BIRP. Collect records on at least 90% of Baltimore's 0-3 year-old cohort. Collect vaccination histories on at least 90% of BIRP 0-3 year-old records. Contribute measurably toward attaining and sustaining Year 2000 and 2010 Public Health goals for childhood vaccination coverage. In collaboration with the Maryland Department of Health and Mental Hygiene, upgrade BIRP system software, operating platform and supporting communications. "BIRP v2000" will serve as the core to Maryland's "ImmuNet" state immunization registry. Ensure a working linkage with "ImmuNet" to allow transfer and synchronization of other jurisdictional (cross country, interstate) data. Formalize inter-agency agreements with the Baltimore City Public School System, Department of Social Services, Women, Infants and Children (WIC) Program, and other City and State child health programs, to share technologies and information. Solicit support from MCO's and third-party payers, including Maryland State Medicaid, to gain access to secondary data sources such as billing and enrollment records. Define and implement actions to ensure a high level of BIRP data integrity, including error identification and correction (QA). Seek accreditation from CDC/NIP and other professional associations. Increase current levels of public awareness and acceptance of BIRP. Increase health care provider access to BIRP records; increase feedback to clinicians. Ensure that BIRP complies with legislated standards for the privacy and confidentiality of electronic medical records. Complete both qualitative and quantitative evaluation of BIRP 1. utility system; 2. user satisfaction; and 3. contribution towards increasing

primary health care utilization. Evaluation to include the collection of all program direct and indirect operating costs, and a risk/benefit assessment of user fees. Secure standing as an autonomous regional hub to Maryland's "ImmuNet" program. Secure long-term (3-5 year) funding.

Barriers encountered in implementation:	Strategies to overcome barriers:
Registry growth is constrained by a lack of secured long-term financing, coupled with the need for expanded staff and other resources.	The Department continues to work with Registry partners locally, at the state health department and the Maryland Chapter of the American Academy of Pediatrics to identify funding sources. For example, currently under review by RWJ is a Letter of Intent from the Baltimore City Asthma Coalition which, if funded, will support development of an asthma data system which, in turn, would support Registry activities as they relate to integration of asthma data.

Role of health department in implementation, planning, and evaluation:

The Baltimore City Health Department serves as the lead agency for local immunization registry activities.

Accomplishments:

1. Designed and implemented a marketing plan which increased provider participation from 20% to 90% in one year (1998-1999). Provider marketing included a mix of incentives (customization of support services ensuring a "best fit" with clinical practice, thus minimizing the burden of reporting) and mandated reporting through enactment of a Baltimore City Ordinance. 2. Percentage of 0-3 year-olds in BIRP=94%. Percentage of 0-3 year-olds in BIRP with a vaccination history (≥1 vaccine dose)=78%. 3. BIRP has been recognized by the "All Kids Count" program (RWJ Foundation) as one of the nation's leading immunization registries in terms of provider participation and population coverage. 4. Opened communication and trust-building between the Health Department and local health care providers. 5. Building public-private partnerships has played a key role in garnering support, creating solutions, and providing BIRP program oversight. 6. The registry has catalyzed development of a wider population-based maternal and child public health information infrastructure. Discussions have begun on expansion of the registry, using additional modules, to include data on early childhood lead levels, asthma screening, newborn discharge and metabolic screening, and dates of EPSDT well-child services.

Lessons Learned:

Once a robust and viable system is created, widespread implementation requires a balance between one-on-one customized support and economies realized through standardized procedures and the "stick" of mandated reporting. A registry works and grows through commitment, communication and compromise.

Community Collaboration with Family Road of Greater Baton Rouge

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Development of models Promotes compatibile, integrated service system initiatives Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Prenatal care Expanding maternity services Breastfeeding/nutrition/WIC Immunizations Violence prevention/at risk Teen parenting Expanding private sector links Increasing social support Building coalitions & partnerships

Funding Sources:
MCH block grant funds, Private source(s): Women's Hospital funding, Other Federal funds

Budget: $20,000.00

Description:

Family Road of Greater Baton Rouge is an innovative program with provides a single location in which multiple agencies co-locate to provide services for families. The East Baton Rouge Health Unit is participating in Family Road in various areas. WIC is being provided through collaboration with Better Beginnings which offers access to services of an obstetrician for prenatal care. Better Beginnings is providing medical data for WIC staff to be able to provide services at Family Road. The medical data is usually measured by the health unit staff. This has allowed health unit staff to develop an innovative way of providing WIC services for prenatal women. Prenatal women are certified & receiving nutrition education in a group which has significantly decreased the length of time an initial WIC visit takes. It has also resulted in more interaction between the WIC participants and a sharing of ideas. The East Baton Rouge Health Unit also participates in Family Road by providing evening hours for immunizations at Family Road allowing community access after work hours to continue to improve rates of childhood immunizations. Nurses and nutritionists have joined forces with personnel from private hospitals to provide breastfeeding class: "Breast is Best" offering classes twice a month. Screening for children is sponsored by staff of East Baton Rouge Health Unit on a weekly basis. Our audiologist provides hearing and speech screening with the vision specialists training volunteers to conduct vision screening at Family Road.

Objectives of the activity:

1. Increase the number of prenatal women receiving WIC services in East Baton Rouge parish. 2. Provide WIC services to prenatal women in an innovative manner in order to decrease time in clinic, and provide a homey atmosphere to foster group support. 3. Increase rates breastfeeding infants on discharge from birthing hospitals. 4. Improve compliance with immunization schedules for children. 5. Identify hearing and vision problems in children as early as possible and refer for treatment.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Lack of staff to provide services off-site. 2. Lack of equipment to obtain needed WIC medical data. 3. Resistance to change.	1. Clerical staff for WIC services is being provided through a contract with one of the local birthing hospitals. 2. Through collaboration with Better Beginnings medical data is obtained by the program and shared with the WIC staff. 3. Detailed planning prior to starting services at Family Road. Offered compensatory time to employees working longer hours.

Role of health department in implementation, planning, and evaluation:

The East Baton Rouge Health Unit has met with a variety of community players in planning for these activities. Implementation has required the use of staff to provide the direct services. Evaluation of the WIC portion has been accomplished through ongoing monthly reports.

Accomplishments:

1. A 25% increase in the number of women receiving WIC services prenatally over a six-month period with minimal amount of staff. 2. Significant decrease in length of a clinic visit from 2-3.5 hours to one hour for WIC services compared to visits at the health unit.

Lessons Learned:

1. Planning on the front end of a new project is essential for the project to work smoothly. 2. Innovative projects can utilize a small number of staff and still have a significant impact. 3. Facilitated learning is an excellent use of staff in a WIC clinic and the WIC participants enjoy the process.

Prenatal Through Preschool Healthy Child Initiative

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Population surveys (BRFS, PRAMS, PedNSS, YRBS) Environmental Assessments Hotlines, print materials, media campaigns Prepare, publish & distribute reports Public advocacy for legislation & resources Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Referral systems, resource directories, advertising , enrollment assistance Comparative analysis of HC delivery systems Identify & report access barriers	Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunizations Early intervention/ZERO TO THREE EPSDT/screenings Injury (including child abuse) Lead poisoning Children with special needs Violence prevention/at risk Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Schools & health connections Strategic planning Reshaping urban MCH Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, general state funds, MCH block grant funds, private source, other: Tobacco Tax--Children's Commission

Budget: $150,000.00

Description:

With a focus on children from prenatal through preschool, our mission is to create a community that ensures optimal development of health, emotional well-being, and love of learning, building a foundation for lifetime success for all of Berkeley's children. The cross-cutting themes agreed upon by the Initiative are socioeconomics and race, emotional well-being, love of learning, disabilities, and quality assurance. The Initiative began in the office of the Mayor, was transferred to the Health Department (Maternal, Child Health), and intersects with nearly every Berkeley community.

Objectives of the activity:

The objectives for FY 2001 are to: 1. Convene neighborhood residents and consumers to determine barriers to service and opportunities for systemic reform and community solutions. 2. Merge the Prenatal Through Preschool activity with the CityWide Collaborative for Youth, which services K through 12 students. 3. Convene practitioner-level feedback from community and providers. 4. Develop continuation and funding plan for maintenance of multidisciplinary team and neighborhood support activities. Evaluation indicators will be through focus groups, satisfaction surveys, functioning committees, inventory of services on the WEB, needs, gaps and barriers identified and resolutions developed, continuation action plan completed and accepted by City Council, School Board, and University.

Barriers encountered in implementation:	Strategies to overcome barriers:
FUNDING! NONCOERCED RESIDENT PARTICIPATION! Originally, in 1997, this Initiative was from the Mayor's Office. It got off to a roaring start and MCAH was a part of it. The City Manager determined in 1999 that this type of Initiative should not rest in the Mayor's Office and it was transferred to MCAH in the Health Department on July 1, 1999. Unfortunately, funding was not secured. MCAH had to spend a great deal of time stabilizing the 70-some odd organizations and individual residents, school districts and city and writing for grants to support the activity. Ultimately, this was successful, but stressful. Community residents did not really participate (only one person) at the beginning. We are now trying to incorporate residents and will need to transform some of our thinking--challenge.	Fortunately, the citizens of California voted for a tobacco tax and Alameda County quickly organized to spend its share of the funding. The City of Berkeley (MCAH) applied for and received some funding to support the program and leveraged it with State and Federal dollars. A significant portion of the activity is to involve community residents. A community action team has been developed and is driven by community issues. However, coordinating the two activities is a challenge.

Role of health department in implementation, planning, and evaluation:

Maternal, Child and Adolescent Health has been the lead in this project for one and one-half years. Our role has been to financially stabilize it and to continue to build the trust and working relationships of the following organizations: City of Berkeley, Berkeley Unified School District, University of California, multiple community-based organizations, community clinics, private organizations, parents and residents. MCAH has worked with the various participants to help them apply for and receive funding from the tobacco tax; so that all together, Berkeley has received $1.6 million in one year.

Accomplishments:

Development of a close "Working Group" consisting of 20 individuals (over three years) that is committed to continuation of the work. The Networking has been productive and supportive. The Working Group has developed a collective mission. The group has decided that by the end of the fiscal year (June 2001. the responsibility for the continuing management of the Initiative will be transferred to an independent community based organization.

Lessons Learned:

Relationships with public officials need to be constantly developed. Updates are critical, so insure advocacy at multiple levels so that diversified funding is possible. Communication with all the partners in the Initiative is also very essential. Nobody wants to be left out in some of the decision making. Do not underestimate the personnel and time commitment necessary for this communication to take place.

Collaborate & Coordinate Outreach & Education Efforts with CHIP

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Promotes compatibile, integrated service system initiatives Staff Training Support of health plans/provider networks Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Identify & report access barriers	Family Planning Breastfeeding/nutrition/WIC Immunizations Violence prevention/at risk Increasing access to Medicaid

Funding Sources:
Other Federal funds

Budget: $20,000.00

Description:

Implementation of a program that assists in enrollment of children in the SCHIP Program through the WIC, Family Planning and Immunization Programs.

Objectives of the activity:

1. Staff training regarding SCHIP application process and eligibility. 2. Number of clients of Central District Health Department who have access to and (optional) assistance in completing the SCHIP application. 3. Follow up by health department staff to determine the disposition of the application. 4. Quarterly SCHIP educational presentations to clients, including evaluation of these presentations.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Some staff are reluctant to take on the additional work including optional assistance in completion of the SCHIP application. 2. Training a health department staff person to do the SCHIP application was somewhat cumbersome and questionable, because there are resource Medicaid staff people available to do the kind of training required.	1. Barriers are being overcome by regular meetings and positive encouragement. 2. The SCHIP program regional representative gave incentive CHIPmunks (similar to Beanie Babies) for the customer service representative staff windows. 3. Training will be an ongoing process to keep all staff involved, informed and up-to-date.

Role of health department in implementation, planning, and evaluation:

The activity is a program of the health department as contracted with the Division of Medicaid. It requires the cooperation of the Family Planning, Immunizations, and WIC program. The health department Administration Team is supportive of this process.

Accomplishments:

1. Accumulation, presentation, and distribution of SCHIP informational materials and applications. 2. Majority of the staff are trained. 3. Powerpoint and application presentation acquired/developed. 4. Beginning of the follow-up process with the clients who received applications.

Lessons Learned:

1. Importance of programs working together. 2. Importance of including staff input from all levels of the organization.

Improving Birth Outcomes in Boston

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
	Preconception promotion Family Planning Prenatal care Family Violence Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Schools & health connections Other outreach activities Increasing social support Case coordination Increasing access to Medicaid Staff training Reshaping urban MCH Building coalitions & partnerships Infant/child death review

Funding Sources:
City/County/Local government funds, Private source(s): Foundation Support, Third party reimbursement (Medicaid, insurance)

Budget: $400,000.00

Description:

The overall goal of the initiative is to improve birth outcomes in Boston, with a particular emphasis on reducing racial disparities, by improving the health status of women of childbearing age. This will be accomplished by restructuring service delivery to women of childbearing age at community health centers and hospital outpatient departments. Strategies will be developed and implemented that improve the utilization of routine primary care prior to or after a pregnancy and to assure that effective linkages with appropriate social services are achieved and maintained. Through continuous outreach, use of an effective screening tool, identification of medical and social risks prior to pregnancy, linkage to necessary social and medical services and improved satisfaction with care, it is believed that further reductions in Boston's IMR can be achieved. Ultimately, we anticipate that the project will result in new models of health care delivery for low-income women; a model with improved access to care, a reconfigured and appropriately trained primary care team, increased recognition of the predictors of poor pregnancy outcomes, and ultimately decreased racial disparities in the rates of low birthweight babies and infant mortality.

Objectives of the activity:

GOAL 1: Reduce the fragmentation of healthcare of reproductive aged women, especially those with increased medical and social risk. 1. Partnership with two community health centers in year 1 willing to restructure the process in the primary healthcare setting; 2. Strengthen interdisciplinary teams in the primary care setting at each site to include physicians, nurses, social workers, and outreach educators/case managers; 3. Identify a minimum of 50 adult women at each site who are of childbearing age and who have not engaged in

comprehensive health care. GOAL 2: To systematically identify medical and social risk among women prior to pregnancy and to link women to appropriate services and care. 1. The development and field testing of a screening/assessment tool for use with identified women at each of the sites; 2. The identification and reduction of barriers to care through linkage to services such as: insurance coverage, transportation, child care, scheduling of appointments, language capacity; development of an on-line resource directory to facilitate access to needed services; 3. The provision of reports designed for use by the patient and physician at the primary care visit, enabling the patient to confirm health concerns, frame questions, and list other resources she may wish to access, and the physician to understand the totality of her patient's health issues; 4. The provision of advocacy skills to the patients to help ensure that all of their health related concerns are addressed in visits to their providers. GOAL 3: To improve patient satisfaction with the interpersonal aspects of healthcare, especially among women of color. 1. The demonstrated use of the interdisciplinary teams by involved women, such that they remain connected to care; 2. The development of training and educational materials for providers that will increase their knowledge of the health issues for women of childbearing age, especially low-income women and women of color such that provider communication skills are improved; 3. The improved satisfaction of women participating in this project as measured by satisfaction surveys.

Barriers encountered in implementation:	Strategies to overcome barriers:
Development of a comprehensive assessment tool that incorporated both medical and social concerns without being burdensome/inappropriate for the patient. Reconfiguration of primary care teams, especially the inclusion on these teams of an outreach educator. Identification of "nonmedical" services and supports that were easily accessible to women. Obtaining reimbursement for outreach and case-management services.	1. Worked for over a year with health providers, advocates, and patients to develop an instrument that met the needs of each group; 2. Training has been implemented at each site to articulate roles and responsibilities; 3. The sites are linked to partners who can quickly respond to the common needs expressed by women participating in the project; 4. A coalition has been formed to work closely with insurers and payers to present information documenting the effectiveness of case-management/outreach in improving patient satisfaction, compliance with medical advice, and health outcomes.

Role of health department in implementation, planning, and evaluation:

The Boston Public Health Commission has played a leadership role in project implementation, including contributing significant financial resources, staff support, undertaking data analysis, and convening a city wide task force to oversee the development of project guidelines, policies, and interventions.

Accomplishments:

Identification of two community health centers and one hospital outpatient clinic as project sites. Provider training at each site (cultural competency, women's health, resource linkage). Placement of an outreach educator as a primary care team member at each site. Development and field-testing of a comprehensive assessment tool. Identification/enrollment of women in the project at each site. Meetings with State Medicaid Agency to discuss reimbursement for outreach/case-management services. Development of computer software to "read" assessment forms and print out two reports, one for the provider, one for the patient. Development of evaluation protocol/tools for the project. Successful award of city and foundation funding for the project.

Lessons Learned:

It is possible to tackle a long-standing problem (racial disparities in infant mortality and low birthweight rates) in an innovative manner with the appropriate use of data, and by garnering support from key constituents, including consumers, providers, and elected officials.

Public Health Nursing Violence Prevention Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Implement public MCH Program client data systems Analysis of demographics, economic status, behaviors, health status Hotlines, print materials, media campaigns Implement/support education services for special MCH problems Prepare, publish & distribute reports Public advocacy for legislation & resources Promotes compatibile, integrated service system initiatives Consistent, coordinated policies across programs MCH legslative activity Provide infrastructure/capacity for MCH functions Staff Training Support of continuing education Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify & report access barriers	Prenatal care Expanding maternity services Home visiting Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunizations EPSDT/screenings Injury (including child abuse) Children with special needs Violence prevention/at risk Teen pregnancy Teen parenting

Funding Sources:
City/County/Local government funds, MCH block grant funds, Other Federal funds

Budget: $210,000.00 for Laramie County implementation

Description:

"Public Health Nursing Violence Prevention" Legislation became effective July 1, 2000. The PHN Violence Prevention Program places public health nursing in state statute for the first time. The bill passes due to the efforts of MCH Program staff at the state level who provided education and interpreted research illustrating that young, first-time families are more likely to have successful outcomes if PHN home visiting is started during pregnancy and continued for up to two years. TANF money has been earmarked to fund these enhanced MCH services.

Objectives of the activity:

Specific evaluation and reporting criteria have been defined for the expanded MCH services: 1. 90% of eligible pregnant women will receive a prenatal contact by a public health nurse. 2. 90% of all eligible new mothers will receive a welcome home visit by a public health nurse. 3. 75% of eligible first-time mothers will be enrolled in the Olds' Home Visitation program.

Barriers encountered in implementation:	Strategies to overcome barriers:
Identifying eligible populations, enrolling eligible populations, recruiting the appropriate number of Public Health Nurses to provide the increased level of service.	Developing and strengthening partnerships with WIC, Family Planning and hospital staff for early identification of eligible clients.

Role of health department in implementation, planning, and evaluation:

During the Legislative session, we were called on frequently to assess the impact such programming would have in our local county. During planning and implementation, our local staff were required to identify local strategies for achieving the objectives in Laramie County.

Accomplishments:

Planning implementation strategies and securing adequate funding for program implementation.

Lessons Learned:

Much to be learned over the next year during implementation phase.

"Stop the Hurt! Stop the Pain!"

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Has this activity been formally evaluated?
Don't know

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
	Family Violence Building coalitions & partnerships

Funding Sources:
Other: Neopolitan Lighthouse

Budget: Not Specified

Description:

The Illinois Coalitions Against Domestic Violenc and other domestic violence agencies have targeted the medical community to identify survivors of domestic violence. The WIC Program was selected because of its unique population and the lack of domestic violence outreach services. Chicago Department of Public Health Nutrition Services/WIC Program drafted an assessment tool to aid in the screening of clients in need of services. A medical Advocate from Neopolitan Lighthouse is located at a specific WIC site three days per week to educate clients and staff, complete the assessment tool, discuss domestic violence and the Illinois Domestic Violence Act and answer any questions clients might have.

Objectives of the activity:

1. To provide clients with medical advocacy service for women of the WIC Program and their children. 2. To provide medical advocacy training and education for staff and clients at each WIC site.

Barriers encountered in implementation:	Strategies to overcome barriers:
All the women were not screened with the assessment tool because the women were escorted to the WIC Program by husbands or boyfriends. The medical advocate would only approach these women if she could speak to them alone at some time during their appointment. The chances are very high that if the women was indeed a victim of domestic violence, her abuser might insist on accompanying her to her appointment.	The WIC Medical Advocate assists the women in the completion of a self administered screening tool and in the one on one private and confidential interview to explain the program and refer for more in-depth counseling.

Role of health department in implementation, planning, and evaluation:

The Chicago Department of Public Health met with Neopolitan Lighthouse to discuss the lack of domestic violence outreach services in the medical community. It was decided that the WIC Program locations had not been targeted. The WIC Program collaborated with Neopolitan Lighthouse to identify staff training and site locations for the project.

Accomplishments:

From November 1, 1996 through December 31, 1999, approximately 3000 women were screened, and 333 women were identified as being victims of domestic violence. The Medical Advocate provided the women with a total of 433.5 hours of individual counseling and 241.5 hours of Illinois Domestic Violence Act (legal) counseling.

Lessons Learned:

There is a need to provide ongoing screening for the women of the WIC Program. There should be a staff person on site at least part-time. Although clients are screened and identified as being a victim of domestic violence, many women fail to show up for their follow-up counseling sessions. These clients reschedule but still don't come in. The advocate must continue to contact the clients to encourage the women to seek follow-up counseling and provide tokens to attend sessions.

Enhancing MCH Research

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Prepare, publish & distribute reports Special studies	Building coalitions & partnerships Building MCH data capacity

Funding Sources:
Other: No Specific Funds Allocated For This Activity

Budget: Not specified. Primary cost is staff time. There are minor expenses for copying, computer use, and supplies.

Description:

In order to improve our understanding of health status and health care issues affecting mothers and children, we are enhancing our research capabilities by collaborating with the Ohio State University School of Medicine and Public Health. Specifically, we are working with MPH and PhD students to undertake special research projects that are mutually beneficial. These projects help develop the students data manipulation and analytic skills and help our Department glean important information from these studies that we have not had the time to do.

Objectives of the activity:

To improve the health of and the health system for mothers and children through research and dissemination of information. To collaborate with students and faculty from The Ohio State University School of Medicine and Public Health in order to link academia and public health at the local level.

Barriers encountered in implementation:	Strategies to overcome barriers:
There have not been barriers for implementation. Planning for working with students requires communication, commitment and coordination among the internal Department Teams involved. Internal partners have involved the Family Health Policy Team and the Title V Perinatal Program; and the Family Health Policy and Epidemiology Teams.	It has been helpful to have students meet program staff, spend time in the clinic settings and share findings directly with staff. It is important to be clear on time commitments--time spent with students, meetings with students/faculty, attendance at presentations at the university.

Role of health department in implementation, planning, and evaluation:

The Columbus Health Department is committed to increasing linkages between academia and public health. Our department has two split funded positions with the School of Public Health. A number of staff give lectures at the university and we collaborate on research projects. A major role for the Department is establishing and maintaining relationships at the university and continually looking for ways to work together.

Accomplishments:

Columbus has seen a dramatic increase in the Hispanic population and our Perinatal Program is serving an increasing number of Hispanic women. We wanted to know more about the experiences of these women in our program. A Hispanic student conducted a study to look at access, utilization and outcomes for women enrolled in the program. In addition to program data analysis, the researcher spent time in the clinic with clients. The study resulted in helpful observations and recommendations. We are currently working with another student to analyze fetal death records.

Lessons Learned:

The collaborations have been a win/win for all parties involved.

Dallas Child Injury Prevention

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Tracking Systems Staff Training	Injury (including child abuse)

Funding Sources:
MCH block grant funds

Budget: $20,000.00

Description:

The City of Dallas Department of Environmental and Health Systems (ENS) Injury Prevention Coordinator reviewed findings from the most recent Dallas County Child Dealth and Infant Mortality Review Team and found that 54% of Dallas county accidental deaths among children were a result of motor vehicle accidents. Using this finding, the coordinator conducted an assessment of all injury prevention activities within the department and found no child passenger safety activities in the department, few resources, and no certified training expertise. Consequently, the Injury Prevention Coordinator completed a four-day child passenger safety technical course, and became the department's first certified child passenger safety technician. In January 1999, the Injury Prevention Program began by conducting a car seat observation survey at five WIC clinics in the Southeast Service District. Over 80% of children observed were not safely restrained, and 38% did not have a car seat. In addition, focus groups were conducted to gain qualitative information related to child restraint. Lack of parental information about proper child restraint installation/restraint use; lack of perceived risk of injury, fear of placing the child in the backseat, and concern for comfort of the child were major reasons for noncompliance. From the data gathered, EHS has developed a department-wide plan to increase child restraint compliance among its client population as well as members of the community. Currently, the program is planning a second observation survey to determine effectiveness of the program and will train additional staff to become certified child passenger safety technicians.

Objectives of the activity:

Healthy People objective 15.20--To increase the use of child restraints/seat belt usage in the City of Dallas to 100% by the year 2010.

Barriers encountered in implementation:	Strategies to overcome barriers:
Impacting systems (e.g. WIC, well-child clinics, private/public health care providers) to provide child restraint interventions for their patient populations.	We have begun collecting monthly encounter sheets from providers listing how many were counseled, where the child sits (front or back seat), if they have a car seat, etc. By collecting the data from the providers, we hope to make the counseling intervention institutionalized in their system.

Role of health department in implementation, planning, and evaluation:

The health department has planned and implemented the project and will evaluate the activities.

Accomplishments:

Baseline data on actual child restraint is now a known health indicator in the southeast Dallas service district. Over 3,000 children attending well child clinics, and child care financial aid services have received direct counseling interventions. Data on interventions directed to WIC participants will soon be collected monthly. EHS staff that were previously unaware of the problem are now trained and contributing to the decrease of childhood injury and death due to motor vehicle accidents.

Lessons Learned:

Changing the way systems conduct business is very difficult and requires a great amount of follow-up, monitoring, and support. Just training someone to provide an intervention without support and follow-up will eventually fail or cease.

Adolescent Health & Wellness Center

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Analysis of demographics, economic status, behaviors, health status	Prenatal care
Community perceptions of health problems/needs	Home visiting
Hotlines, print materials, media campaigns	Breastfeeding/nutrition/WIC
Newsletters, convening focus groups, advisory committees, networks	Immunizations
Provide infrastructure/capacity for MCH functions	EPSDT/screenings
Staff Training	Expanded child health services
Support of continuing education	School-linked/based services
Provide outreach services	Violence prevention/at risk
Prior authorization for out-of-plan specialty services	Case coordination
Managed Care model contracts & access issues	Increasing access to Medicaid
	Managed care initiatives
	Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Private source(s): Grants from local hospitals, Third party reimbursement (Medicaid, insurance)

Budget: $450,000.00

Description:

The Adolescent Health and Wellness Center (AHWC) is a health clinic exclusively serving adolescents ages 10 through 19. Total adolescent health care includes physical, emotional, social, and mental health services including prevention education. Medical services include screening, diagnosis, and treatment for illnesses, and sexually transmitted diseases, as well as work and sports physicals, pap and pelvic examinations, birth control, vision and hearing screening, and immunizations. The health assessment for each new patient includes a psychosocial assessment, reviewing social, emotional and mental health issues. If significant problems are identified, counseling services are available. Social services include follow-up, referral services, and case management. Health and prevention education are routinely provided with all adolescent health care. Many adolescents are concerned about sexuality care. Gynecological exams, STD testing and treatment, and pregnancy prevention are all important aspects of the services provided by AHWC. AHWC was a private non-profit agency for nearly six years. It was established and financially supported by the Combined Health District, four local hospitals, and the local mental health board. Because significant changes in the health care system had a major impact on the financial bottom lines of the local hospitals, it became difficult for them to continue the level of financial support to the AHWC. Discussions between the hospitals, the health district, and local politicians led to development of a plan to save the program. The program was merged with the Health District. This offered a win-win situation: services for adolescents would continue without interruption, AHWC staff could transfer to the Health District, and the Health District could extend its medical services to adolescents.

Objectives of the activity:

1. To provide comprehensive medical services to 1,000 adolescents in Montgomery County regardless of ability to pay. (To serve a minimum of 600 uninsured patients). 2. To reduce the percent of pregnancies among established, uninsured, sexually experienced patients to no more than 10%. (To provide pregnancy prevention to a minimum of 150 sexually experienced patients. To provide sexuality and "safer sex" education to 50% of sexually experienced patients.)

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Prior to becoming part of the Health District, AHWC provided sexuality services to teens in a confidential manner on demand, without parental consent. The Health District, a public agency regulated by state laws and regulations, is restricted in providing some confidential sexuality services to teens. When the Center merged with the Health District, confidential services for adolescents were limited to those services dentified by state statute as confidential. The State of Ohio does not have statutes addressing confidential contraceptive care. The Health District suspended provision of confidential birth control until the legal ramifications of confidential contraceptive care for adolescents could be determined. 2. Parental consent for general adolescent health care is also an ongoing barrier. Often parents give their adolescent children a very independent role in their health care. Acquiring parental consent/participation in their child's care has been problematic. Furthermore, acquiring parental consent for birth control previously provided with only the adolescent's consent, has been an issue for many of our teen patients.	1. Long resolution process beginning with an in-depth search of state statutes for any reference to adolescent pregnancy prevention/family planning or right to privacy. Ohio law is totally silent, regarding contraceptive services. Planned Parenthood of the Miami Valley included AHWC in its Title X application for family planning funding. The Center requested assistance with the purchase of Depo Provera provided 300 doses of Depo Provera. Agencies who receive Title X federal funds are required to provide confidential services (for family planning). As a contract agency of the subgrantee, we needed to know if we were required to comply with the federal mandate, and are we legally protected by this mandate? Legal Counsel for the Health Department completed a comprehensive review of the legal ramifications. Subsequently, we decided to reinstate confidential contraceptive services if we obtain parental consent, continue to obtain informed written consent from the adolescent, and we tightened our contract with Planned Parenthood.

Role of health department in implementation, planning, and evaluation:

The Combined Health District of Montgomery County helped to establish the AHWC in 1993. They have been active on the Board of Directors (planning, implementing and establishing policy for the program), the Medical Advisory Board (establishing medical protocols and reviewing quality assurance), as well as an active funding agency. Internal evaluations have been conducted for the Board each year. When the local hospitals began to decrease their contributions and could no longer sustain the level of charity care required to operate the AHWC, the Health District incorporated the program into their Community Health Division. Effective July 1, 1999, the AHWC became a program supported and operated by the Health District. Adding this program has increased the Health District's capacity to serve adolescents, providing specialized services to meet their individual needs.

Accomplishments:

1. During the last fiscal year (June 1, 1998 through July 1, 1999) the Adolescent Health and Wellness Center treated a total of 1,128 patients, 7733 (65%) of whom were uninsured and could not pay for their health care needs. 2. The objective of reducing teen pregnancies to no more than 10% was met. During the fiscal year, 35 (5%) uninsured patients became pregnant. Approximately 300 patients received pregnancy prevention services. The objective to educate patients about "safer sex" was met. Out of 586 sexually experienced patients, 368 (63%) received education about condom use.

Lessons Learned:

1. Although adolescents appear to be the healthiest population, they in fact, need health care just as much as other population groups. 2. Adolescents prefer to come to the doctor's office independently, without their parents present. Provision of confidential sexuality care is vital to the sexual health of many adolescents. 3. Parents often appreciate being able to send their adolescents to the doctor, without needing to take off work to bring their child for a routine visit.

Denver Public Schools Health Planning Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Prepare, publish & distribute reports Public advocacy for legislation & resources Develop & promote MCH agenda & YR2000 National Objectives Promotes compatibile, integrated service system initiatives Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand system capacity Identify & report access barriers	Expanded child health services School-linked/based services Schools & health connections Strategic planning Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, Private source(s): Private Foundation Funding

Budget: $250,000.00

Description:

The project is a needs assessment and strategic planning process for health services provided to school-aged children and youth attending Denver Public Schools. Activities include needs assessment, resource assessment and development of a model for the redesign of health services delivered in Denver Public Schools through personnel and linkages with outside providers.

Objectives of the activity:

1. Develop a comprehensive plan to provide health and mental health services to DPS students. 2. Develop a method to evaluate and monitor the delivery of health services to DPS students. 3. Develop a mechanism to finance the health and mental health services needed by DPS students. 4. Develop a recommendation for the organizational and administrative structure and governance for a coordinated school health program. 5. Develop a timeline for implementation of the coordinated health and mental health services plan. 6. Develop and implement a mechanism to implement an external evaluation of the project, once underway.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Reluctance on part of school staff to participate with outside providers in the discussion of services provided in the Denver Public Schools. 2. Shortage of resources needed to truly meet the needs of students.	1. Constant focus on the higher goal of meeting the needs of children and not the staff providing them with services. 2. Explanation of alternative mechanisms of financing.

Role of health department in implementation, planning, and evaluation:

Health Department has been instrumental in the development and implementation of the planning project. Leadership of the project has been provided by the Health Department.

Accomplishments:

1. Development of comprehensive needs assessment. 2. Development of a preliminary plan to provide services to DPS students. 3. Development of recommendations for organizational and administrative structure for the program.

Lessons Learned:

Progress is very slow in collaborative ventures of this type. Cannot spend too much time generating support for a restructuring of service delivery.

Project THRIVE

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems Development of models Promotes compatibile, integrated service system initiatives Staff Training Provide outreach services Transportation & other access-enabling services Referral systems, resource directories, advertising , enrollment assistance Provide, arrange, administer direct services	Home visiting Low birthweight/infant mortality Early intervention/ZERO TO THREE Lead poisoning Children with special needs Schools & health connections Other outreach activities Case coordination Staff training Reshaping urban MCH

Funding Sources:
General state funds, Other: Wayne CountyCoordinating Council

Budget: $166,000.00

Description:

The purpose of Project THRIVE is to develop, implement and evaluate a comprehensive, coordinated system of intraprogram referral and service delivery at the Detroit Health Department. The participating programs are Children's Special Health Care Services, Healthy Baby Transportation Services Detroit Healthy Start, Grace Ross Health Center Pediatrics Clinic, Women, Infants and Children supplemental food program (WIC) and Childhood Lead Poisoning Prevention Program. Program-eligible infants and toddlers, birth to 36 months, are recruited from the children currently being seen through the above Department programs. Families in Project THRIVE receive necessary screening services, parent interviews, health appraisals, and comprehensive developmental evaluation. All this information becomes the basis for an individualized family service plan (IFSP). This is the Early On Michigan process.

Objectives of the activity:

To provide families of children, birth to 36 months, access to Health Department services that support the improvement of health status and developmental growth. To reduce unnecessary duplication and improve delivery of services. To increase the number of Early On Part C only eligible families from Detroit Health Department programs in addition to Children's Special Health Care Services.

Barriers encountered in implementation:	Strategies to overcome barriers:
The best method to implement this project would be to use existing staff for client data collection and service provisions (demography and client concerns). However, existing staff and managers view this as more work with little or no increase in funding. Other barriers include: client cannot be located, age ineligibility, lack of developmental delay or established condition and large numbers of ineligible clients were found.	The grant was used to hire paraprofessional outreach staff, contractual evaluation staff and to provide staff training.

Role of health department in implementation, planning, and evaluation:

It is the responsibility of the Detroit Health Department to plan, implement and evaluate Project THRIVE.

Accomplishments:

Hired 15 paraprofessional Parent Advisors to perform outreach and recruitment activities. Hired 15 contractual Special Education professionals to administer a comprehensive developmental evaluation tool. Of the families recruited, 20% were found in CSHCS database (duplicates). Over 90% of eligible children have been identified as having developmental delays. Of those children identified with developmental delays, over 50% have received the parent interview, health appraisal, and IFSP development (Early On Process). Of those children identified with developmental delays, 90% of the families have received health and developmental education information. Of those children identified with developmental delays or established conditions, the following are the percentages of children identified with developmental delays (N=258) from each participating program: Childhood Lead Poisoning Prevention Program (51%), Women, Infants and Children Supplemental Food Program (WIC) (6%), Grace Ross Health Center-pediatrics (5%), Detroit Healthy Start (14%), Healthy Baby Transportation Services (17%), Other (nonhealth department sources) (7%).

Lessons Learned:

1. There is a need to institutionalize this type of process. One of the programs does not have the staff or the capacity to provide services to large populations. By sharing the information and integrating the services, there will be less fragmented and/or duplication of services. 2. We need to have processes in place to reduce unnecessary duplication such as automatic references to existing databases. 3. Use of trained staff through contractual arrangements with other public agencies is a good thing. However, adequate funds are needed to achieve this level of cooperation. 4. Paraprofessionals work well at outreach and recruitment activities. There is a rapport they develop that engages prospective clients. 5. The outreach and recruitment workers (Parent Advisors) were able to develop relationships with participating programs. The program staff would refer potentially eligible families. These relationships between program staff and outreach workers need to be maintained.

DINE for LIFE

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Environmental Assessments Hotlines, print materials, media campaigns Culturally appropriate health education Prepare, publish & distribute reports Develop & promote MCH agenda & YR2000 National Objectives Newsletters, convening focus groups, advisory committees, networks	School-linked/based services Schools & health connections Other outreach activities Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: $413,248.00

Description:

The DINE for LIFE program was designed and implemented to improve the nutrition and physical activity knowledge and behaviors of food stamp eligible individuals in Durham County. Population-based nutrition services are provided in 10 elementary schools, two middle schools and the community at-large to increase the number of individuals whose daily activities and choices reflect the U.S. Dietary Guidelines. The program, initiated in 1998 and partially funded by the USDA, will complete its second full year in September 2000. DINE for LIFE nutritionists provide a variety of services in the community. In the school settings, efforts are focused on organizing school-wide and cafeteria health and nutrition programs, incorporating nutrition lessons into the existing curriculum, addressing environmental and policy issues, and teaching targeted nutrition and physical activity messages in the classroom. Efforts in the community at-large include continued and expanded nutrition education for groups, identification and training of lay nutrition advisors, continued community partnerships, and a social marketing campaign. The school and community programs, although delivered in separate channels, are designed to enhance the goals and objectives of each other for greater awareness and behavior change.

Objectives of the activity:

33% of group participants will report a likelihood to make positive nutrition changes. 10% of students will increase knowledge and/or consumption of fruits/vegetables and calcium-rich foods. 10% of students will increase knowledge or behaviors related to increased physical activity.

Barriers encountered in implementation:	Strategies to overcome barriers:
Ironically, one of the largest challenges is related to the strong emphasis placed on improving academic performance in the public school system. This factor, coupled with meager school health funding, has led to a declining commitment and emphasis on health programming in the schools. In addition, a myriad of policy and environmental barriers exist in public schools, preventing the opportunity for children to follow the U.S. Dietary Guidelines related to nutrition and physical activity.	Nutritionists increase awareness in schools of the evidence linking nutrition and physical activity to absenteeism and academic performance. Their presence in schools underscores the public health department's commitment to supporting academic performance. The DINE Team has strengthened community partnerships with school and community leaders to raise awareness of environmental and policy barriers and provide leadership in formulating strategies for positive change.

Role of health department in implementation, planning, and evaluation:

The Nutrition Division, one of the seven divisions in the Health Department, evaluates and provides fiscal management of the program. The Nutrition Division is responsible for creating, executing and evaluating a nutrition education plan as stated by the Federal Food Stamp Education Plan each fiscal year.

Accomplishments:

Over 3,500 children have been reached with school-wide promotions or classroom lessons. Presurveys and postsurveys of 344 children showed a significant improvement in knowledge and behaviors related to target messages. For example, the number of children eating a vegetable at lunch increased by 26%.

Lessons Learned:

Consistent and targeted nutrition and physical activity messages can lead to improvements in both knowledge and behavior. Greater positive change is likely to take place when environmental and policy barriers are addressed.

Mobile Clinic

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Provide outreach services Transportation & other access-enabling services Referral systems, resource directories, advertising , enrollment assistance Provide, arrange, administer direct services	Mobile Clinics for outreach

Funding Sources:
General state funds, MCH block grant funds

Budget: $120,000.00

Description:

After two years of grant writing to obtain money for a mobile unit, we were granted the amount. The ordering and all the details took close to 10 months. Now, the educators coordinate and meet with the different factories to obtain permission to provide women's health on the mobile unit.

Objectives of the activity:

To provide low-income (working) women reproductive health servces with less or a small loss from their income, by providing a much needed service on-site for the women.

Barriers encountered in implementation:	Strategies to overcome barriers:
Low show-rate a clinics even though the schedules were changed to include evenings and Saturdays. El Paso has many factories where a large amount of women are employed. Many of these women are paid by quota versus hourly pay. Many of them could not afford a decrease in their checks because they had to take time to attend a clinic.	The mobile unit is parked at the factories, and the women come in for their exams and choice of contraceptive, without losing too much time and decreasing their production or quota.

Role of health department in implementation, planning, and evaluation:

We were not part of the health department, but we are part of the County Hospital (Thomason Hospital).

Accomplishments:

Because we have a mobile unit, we can provide women's health care just about anywhere that we are asked. The staff enjoys traveling and providing a service that is much needed.

Lessons Learned:

A mobile unit is costly to maintain ($5,000/year), especially the generators. I suggest to do a lot of research before you think of buying one, to avoid suprises.

Gentle Touch: A Violence Prevention Curriculum

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Maternal, fetal/infant, child death reviews Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them	Early intervention/zero to three Expanded child health services Family Violence Expanding private sector links Schools & health connections Increasing social support Staff training Reshaping urban MCH

Funding Sources:
City/County/Local government funds

Budget: The original development and printing were within the department. Sales are now funding continued printing and marketing.

Description:

A Gentle Touch is a 10-step, skills-based violence prevention curriculum that health care and other providers can share with parents to guide and shape their children's behavior from birth to age five.

Objectives of the activity:

A curriculum developed by Public Health Nurses for use in health care, child care, and preschool settings. The 10 lessons are easy to incorporate into a well-child exam or parent meeting. The lessons provide parents with tangible violence prevention skills in Gentle Touching, Modeling Behavior, Respect, Being Consistent, Dealing with Anger, Setting Limits, Reinforcing Good Behavior, Responsibility, Resolving Conflict and Gun Safety.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Adding time to an already busy health care visit, day care visit or school curriculum to do the parent teaching. 2. Getting buy-in from parents on the importance of their role in teaching children these skills.	Training other community organizations and service providers to introduce the concept and provide parents with the curriculum in other than the health care setting.

Role of health department in implementation, planning, and evaluation:

Staff nurses from our agency developed the entire curriculum. Evaluation was done by University faculty, community providers and health departments.

Accomplishments:

The curriculum has been translated into Spanish, and a training video has been made in both Spanish and English. Over 500 copies have been sold.

Lessons Learned:

Encouraging staff and allowing them freedom to develop an entrepreneurial project such as this has been extremely rewarding to them and to the agency.

Office Outreach For Breast Cancer

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them	Breast/cervical cancer

Funding Sources:
City/County/Local government funds, Other: Susan G. Komen Breat Cancer Foundation

Budget: $15,732.00

Description:

The Vanderburgh County Department of Health applied for and received a grant from the Susan G. Komen Breast Cancer Foundation to provide education/awareness of breast cancer. We have personally dealt with this disease through having had five coworkers diagnosed with breast cancer in the past three years. Because of this experience, we feel an obligation to educate other women about breast cancer detection. Through this grant we are able to reach out to women in our WIC/MCH clinics, staff and to women in other offices in the Civic Center Complex (where the health department is located. A four-step approach is being used: 1. To design a program that will be taken to various city and county offices to promote the need for "office outreach" to teach all we can about breast cancer awareness and to educate clients and employees on the importance of breast self-exams and mammograms; 2. To provide an educational program with incentives to be taken to our three MCH/WIC and hypertension clinics in the community to promote this cause; 3. To encourage our own health department employees to take this disease seriously and to promote education for breast cancer awareness; 4. To design a booth on breast cancer information that will be taken to various health fairs in the community.

Objectives of the activity:

GOAL 1: By December 1, 2000, the health department will have organized and provided ten breast cancer awareness informational booths to various city and county offices. These booths will encourage women to take time out of their busy schedules to learn about breast cancer and early detection methods. GOAL 2: To provide a luncheon for health department female employees (64. in October 2000, and to have a cancer survivor speak on the importance of early detection methods and taking time out to make this a priority in our lives. GOAL 3: To provide information booths at the three WIC/MCH clinics and Hypertension outreach clinics of the health department to promote breast cancer awareness among 1000 clients that we see and to promote ten breast cancer booths in conjunction with various church and agency health fairs.

Barriers encountered in implementation:	Strategies to overcome barriers:
We are now seven months into this great period and there have been no barriers encountered possibly because of the community awareness of the high incidence of breast cancer and the greatly publicized Susan G. Komen "Race for the Cure" in our community for the past two years. All government offices that were contacted concerning this project have gladly agreed to have the information booth and personal education of their women staff.	N/A

Role of health department in implementation, planning, and evaluation:

The various divisions in the health department have been instrumental in working with the health educators to set up times to have displays in waiting rooms and personal one on one education with female clients that we see in our clinics. Because of our personal experience with so many of our co-workers being diagnosed with breast cancer, this has become a common goal among the staff to do all we can to prevent and fight this disease!

Accomplishments:

As of July 1, one accomplishment is that five hundred women have been reached. We will continue to work on reaching our goal of two thousand women by the end of the year.

Lessons Learned:

As we talk to women we are finding that women are not being taught by their physicians to do BSE on a monthly basis. Many women do not go for yearly physical exams and those who do see their physicians yearly are having a breast exam done by the physician but are not being taught and educated on doing them on a monthly basis. We feel the physicians need to be educated and encouraged to stress the importance of BSE for all women.

Family Violence Prevention Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Newsletters, convening focus groups, advisory committees, networks Staff Training Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand system capacity	Teen parenting Family Violence

Funding Sources:
Other: Title V Part B--Population Based

Budget: $183,000.00

Description:

The Family Violence Prevention Project focuses on primary health education on issues of family violence to school children in grades 5-12. Classes taught include Shaken Baby Syndrome prevention, teen dating violence, conflict resolution, stress reduction, anger management and alternatives to hitting, shaking, spanking. The classes are also offered to parent groups, day care associations, and training workshops for school teachers and administrators. Public awareness campaigns are also an important component of the project through handouts, brochures, videos, and television commercials. Primary prevention is the hallmark of the project.

Objectives of the activity:

The main objective is to reach 1.5 million residents in Tarrant County and to increase public awarness in the community, so that those living in our area of service will know that violence is a preventable learned behavior. By teaching thousands of students each year the project staff imparts the knowledge that anger is a normal emotion which can lead to danger if it is not addressed in a positive and supportive way. Young parents are taught that children model their parents' behavior and that incorporating nonviolent mechanisms into family life will preserve the safety and integrity of the family.

Barriers encountered in implementation:	Strategies to overcome barriers:
Changing the attitudes of the public toward family violence is a hard task. Taking the glamour out of violence is an ongoing effort. Making the public aware of the risks of being affected by family violence necessitates breaking down denial mechanisms which are strong and counter-productive. Cultural barriers include attitudes towards women that put them in inferior positions. Language barriers also impact the education efforts.	By empowering girls and young women, boys and young men to accept the philosophy that family violence is totally unacceptable. By teaching women of all ages that they should never accept battering as a way of life. By getting materials translated into predominant languages spoken in the county. By teaching students about choices and consequences of their attitudes and behaviors.

Role of health department in implementation, planning, and evaluation:

The Tarrant County Public Health Department has guided the Family Violence Prevention Project staff to serve the entire county population at large by endorsing projects with far-reaching effects. The implementation of the activities has been carried out by project staff and members of their planning committee, some of whom are also Tarrant County Public Health employees. The project is evaluated by a medical anthropologist who serves on the faculty of the University of North Texas Health Science Center Graduate School of Public Health.

Accomplishments:

1. Teaching a variety of violence prevention curricula in 15 school districts within Tarrant County. 2. Production and airing of paid television commercials in English and Spanish aimed at ending the cycle of family violence. 3. Art contest for school children based on the theme "Family Violence Touches Everyone" and publication of year 2000 calendar distributed throughout Tarrant County. 4. Recipient of State Resolution (Representative Glen Lewis District 95) acknowledging the efforts of the project. 5. Brochure design, production, and distribution in English, Spanish, and Vietnamese.

Lessons Learned:

More efforts need to be geared toward primary prevention. Since violence is a learned behavior, parents need to be educated about healthy relationship choices and the effects of family violence on children. Adolescents need reinforcement education on conflict resolution, anger management, and teen dating violence.

Weed and Seed/Safe Futures Nurse Home

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Special studies Staff Training Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Preconception promotion Family Planning Prenatal care Home visiting Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunizations Early intervention/ZERO TO THREE Injury (including child abuse) Violence prevention/at risk Teen pregnancy Teen parenting Increasing social support Case coordination Self-efficacy increasing

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: $2,000,000.00 Federal Funds are $25,000 annually for three years from the Department of Justice

Description:

The home visitation model developed by David Olds Ph.D., and colleagues has produced a variety of positive outcomes for low-income mothers and their children. The Fresno Department of Community Health was selected as one of six sites to replicate the model under the Weed and Seed/Safe Futures Nurse Home Visitation Initiative, a cooperative venture with the U.S. Department of Justice (DOJ) "Weed and Seed Program" and the University of Colorado, National Center for Children and Families, and Communities. Public Health Nurses (PHNs) work with women and their families in their homes during the women's first pregnancy and continuing through the first two years of the child's life. The format for visits follows a process, specified in visit-by-visit guideline protocols and reinforces in intensive training provided to all of the nurse home visitors.

Objectives of the activity:

The principal question of this evaluation study focuses on whether the nurse home visitation program can be implemented with fidelity to the original model and to what extent the program results parallel clinical trials. The activity is to implement the program locally maintaining program element fidelity. Program fidelity is determined by the extent to which the programs have 1. recruited and retained a population of low income, first-time mothers; 2. enrolled families early in pregnancy and followed them through the child's second birthday; and 3. conducted visits that are of comparable frequency, duration, and content as those delivered in the randomized clinical trials

Barriers encountered in implementation:	Strategies to overcome barriers:
FUNDING: Initial funding for the six sites was negotiated between the federal Departments of Justice and Health and Human Services which set aside Title IV (federal welfare administrative funds) for the selected sites to cover the	"WE SHALL OVERCOME," is our theme in Fresno. Barriers were analyzed and proposals were developed and implemented as follows: FUNDING: Data played a major role in addressing funding. Because Fresno had already been

program cost during the four-year replication period. However, in August 1996 the federal Welfare Reform Act provided block grants for administrative funds to go directly to the states. While the federal government made every attempt to negotiate with the states on behalf of the sites to receive the funding, the California State Department of Social Services decided at the last minute (after three of six sites chosen were from California) to withdraw their support and refused to provide any funds. PUBLIC HEALTH NURSING SHORTAGE: In spite of recruiting efforts, Fresno, like cities across the State is having difficulty in recruiting and retaining PHNs due to significant increase in demand for nurses compared to the number of qualified nurses and certificated PHNs available. The department was experiencing a 20% vacancy rate at the time of implementation.	selected as a site and the need was so well documented, the county authorized initial funding for the program in January 1997. Following the 1998 Rand report, the model expanded from four nurses serving 100 families in the Weed and Seed/Safe-Futures project area to include 26 nurses serving 650 families community-wide. There are currently 15 PHN nurses and two supervising Public Health Nurses (SPHN) serving 375 families. PHN SHORTAGE: Initially, it was decided to redeploy four Senior PHNs providing services to adolescents under an "Adolescent Family Life Program" funded by the State of California. We directed first-time pregnant teens into the nurse home visitation model and teens with subsequent pregnancies into the state (AFLP) model. We asked the nurses for a minimum two-year commitment in exchange for our commitment to fully implement the program over three to four years. In 1998, the challenge was to recruit and retain more PHNs. This continues to be a challenge. However, the model itself has been one of the best "recruiting and retention" strategies. The initial four nurses redeployed are still participating—two as staff nurse home visitors--and their enthusiasm has helped recruit other nurses (both senior and fledgling). They have offered themselves to the local university's school of nursing as student mentors and advisors for senior focus students and offered semester experience for the public health nursing practicum. The county developed a "nurse permitted" classification allowing those seniors graduating to work with pay until they receive their license, at which time they are promoted to a PHN I position. We have recruited five of our current nurses using this strategy.

Role of health department in implementation, planning, and evaluation:

The program is under the Department of Community Health, one of four departments in the HSS. The Maternal, Child and Adolescent Health (MCAH) Director was responsible for developing the application. The program is located within the MCAH Division, which has been responsible for implementation with significant support in education, training, and technical assistance from the University of Colorado, National Center for Children, Families, and Communities. Evaluation of replication sites is the responsibility of the University of Colorado. Our department provides for the transmission of the data via Internet to the Clinical Information System.

Accomplishments:

The first comprehensive evaluation report on the Weed and Seed/Safe Futures Nurse Home Visitation Initiative, has just been released. The six sites participating in the initiative include: Fresno, CA; Los Angeles, CA; Oakland, CA; Clearwater, FL; St. Louis, MO; and Oklahoma City, OK. Implementation of the nurse home visitation program in Fresno demonstrates: enrollment of very high risk pregnant women; relatively low rates of program attrition among participants; and high mean rates of completed home visits for both pregnancy and infancy phases. Locally, the program continues to receive support, demonstrated by continued allocation of resources for the program. In January 1999, the State Legislative Analyst's Office recommended the legislature encourage local Children and Families First (Proposition 10) Commissions to fund home visitation using the Elmira program model, reflected in the Fresno County Commission's Strategic Plan.

Lessons Learned:

1. Importance of the integrity of research and evaluation of demonstration projects. 2. You can "overcome (barriers)" if you have the right data. 3. Perseverance: Maintaining fidelity to program elements is critical in order to achieve the results demonstrated in the clinical trials. "Stand Tall" to continuing comments by those in communities (not participating) criticizing the program because of the perceived cost (using professional nurses).

Partners For Healthy Families

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Environmental Assessments Public advocacy for legislation & resources Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Home visiting Early intervention/ZERO TO THREE Injury (including child abuse) Teen pregnancy Teen parenting Family Violence Increasing social support Case coordination

Funding Sources:
City/County/Local government funds, General state funds, Other: Jefferson County District Attorney

Budget: $400,000.00

Description:

Partners For Healthy Families is a nurse home visitor program focusing on the needs of first-time, low-income mothers, that was implemented in July 2000. The mothers are provided with visits during their pregnancy. The visits continue until the child is two years of age. The program follows the model developed by Dr. David Olds and covers six domains: personal health, life course development, environmental health, maternal role, family and friends, and use of services.

Objectives of the activity:

1. Reduce the occurrence of infant impairments due to maternal use of alcohol and other drugs, including nicotine. 2. Reduce the number of reported incidents of child abuse and neglect. 3. Reduce the number of subsequent pregnancies to mothers. 4. Reduce the amount of public assistance received by mothers.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Obtaining funding to implement the program. 2. Obtaining funding to sustain the program.	Collaborated with Invest in Kids, a nonprofit group, formed to implement the program statewide. Negotiated with the County Department of Human Resources to allocate TANF monies to implement the program.

Role of health department in implementation, planning, and evaluation:

Jefferson County Department of Health and Environment MCH staff provided information on the program to potential community partners. The program was implemented in July 2000 when TANF funding was received. The department, besides providing nurses for home visits, collects data on each domain. This data is sent to the University of Colorado Health Sciences Center School of Nursing. This data is analyzed at the national level with findings reported back to Jefferson County Department of Health and Environment.

Accomplishments:

Within the first two months of operation, 20 families have been enrolled, with a goal of 100. Tobacco Settlement Legislation (SB0071 allocated up to $3M for FY 00-01 for the Colorado Nurse Home Visitor Program with up to $2M per year to 2008-09 to initiate or to sustain the program.

Lessons Learned:

1. Community collaboration can achieve mutual goals. 2. Persistance in seeking funds from various sources is paying off.

Fetal Alcohol Syndrome Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems Provide infrastructure/capacity for MCH functions Staff Training Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them	Low birthweight/infant mortality Substance abuse prevention Children with special needs Staff training

Funding Sources:
City/County/Local government funds, General state funds

Budget: $11,500.00

Description:

Most children with Fetal Alcohol Syndrome (FAS) are undiagnosed or misdiagnosed. There is no data that provides an accurate picture of prenatal alcohol and drug use in Kent County. Nationally, statistics show that 19% of pregnant women drink alcohol. Estimates for Kent County suggest that 1500 infants are prenatally exposed to alcohol annually. The development of an integrated system of prevention, intervention and treatment services is central to addressing this problem. During this past year representatives from some of Kent County's health care, child welfare, public health and substance abuse treatment systems have met to map out a community standard of care that would address the prevention and treatment of prenatal substance abuse. Fetal Alcohol Syndrome is the leading known cause of mental retardation and one of the three leading causes of birth defects. In an effort to increase identification of FAS, a series of three workshops were held to educate and train community health workers in FAS screening.

Objectives of the activity:

1. Increase community health workers' knowledge of FAS and train nurses in the use of screening tools. 2. Increase referrals to the FAS Diagnostic Clinic at DeVos Children's Hospital for appropriate diagnosis and intervention.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The FAS Diagnostic Clinic at DeVos Children's Hospital has very limited capacity at this time, with only two appointments available each month. There is promise of increased capacity if the demand is sufficient. This raises serious commitment issues for staff willing to do the screening because they want to know that the diagnostic services are indeed available to potential clients. 2. Coordinating efforts within the department required buy-in from two division directors who in turn had to get buy-in from their supervisors to allow for staff release time for the day-long training	1. The Project coordinator offered supportive services by herself and advisory committee members who could be available during the wait time for Diagnostic Clinic appointments. 2. The KCHD is working to minimize cost in service delivery by funneling these clients to community nursing for home visits where the second level of screening can occur without disrupting other service delivery.

sessions. There was a major financial commitment by the agency. The actual implementation of the pre and full screening required setting appropriate procedures in place that were acceptable with both divisions.	

Role of health department in implementation, planning, and evaluation:

The KCHD is responsible for planning and coordinating the training sessions/workshops. A contractual trainer for the Michigan Department of Community Health is conducting the actual training on use of the screening tools. The public health nursing staff in community nursing (field based) and clinical services (WIC, immunizations, child health screening) are responsible for implementing the screening process in their respective work settings.

Accomplishments:

Three training workshops were held between April, 2000 and September, 2000. One hundred ninty-six health care workers have attended. Eighty-five were nurses and others were social workers, substance abuse counselors, health educators and dietitians.

Lessons Learned:

This a difficult area because of the potential for guilt and denial related to the mother's alcohol use during pregnancy. It is not easy to initiate this type of screening in a fast-paced clinical environment. This type of service may be better suited to in-home screening where time is available for dealing with the emotional content. Ongoing support for clients needs to be in place once FAS is suspected.

Statewide Vasectomy Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Analysis of demographics, economic status, behaviors, health status Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Certification & monitoring provider compliance Staff Training Support of health plans/provider networks Provide, arrange, administer direct services	Family Planning Overcoming cultural barriers Expanding private sector links Staff training

Funding Sources:
City/County/Local government funds, Third party reimbursement (Medicaid, insurance)

Budget: $136,000.00

Description:

The statewide male sterilization project began as a local effort when outreach staff, visiting homes of postpartum women, began to see the need for such a program. Guilford County sought funding from the North Carolina Division of Health and Human Resources. Beginning in the late 70's as a one-county vasectomy project, the procedures were performed on-site two evenings per week after family planning clinics had closed for the day. Local board certified urologists came to the health department for the surgical procedures. All case finding, counseling, scheduling, and consents were the responsibility of the health department. In the 1980's, the program was expanded regionally and the state included dollars in our Family Planning Block Grant to hire a coordinator for the project. Currently the project has expanded statewide and has 13 urology practices performing the procedure on clients referred by Guilford County's coordinator. Guilford County trains staff across the state to do counseling and consentsfor men in their area; however, scheduling appointments and follow-up for semen analysis remains the responsibility of Guilford County. Contracted physicians receive $270 per procedure (approximately half the usual charge) and men are assessed a fee on the same adjusted pay schedule used in family planning clinics.

Objectives of the activity:

Current objectives are to keep funding at a level to support 300 procedures each year. These come from the state when budget years allow and from revenue collected from clients.

Barriers encountered in implementation:	Strategies to overcome barriers:
One barrier was to convince state consultants that low-income men would participate in a sterilization project. Another continues to be to keep funding; a shortfall was felt this year due to the coastal flooding last year. Funds have been low and grants had to be written to support the project. Over the years, 80 of the state's 100 counties have referred clients to this project.	We have overcome funding barriers by keeping state officials informed on the number of procedures requested and completed, the counties participating and the satisfaction of participating physicians and clients. We have letters from physicians stating they cannot believe this is a government program because all aspects run so smoothly. Site visits are made annually to physicians to review contracts and concerns. Consumer Concern cards are given to clients for comments.

Role of health department in implementation, planning, and evaluation:

Our health department has taken the lead role in implementing this project. Our health department does training of counselors in other counties, maintains contracts with physician offices, makes payments to physicans, maintains client records and provides client follow-up. Our county covers part of coordinator's salary and benefits, as well as part of the management support position.

Accomplishments:

The program has been in existance and growing for 25 years. The major accomplishments have been the expansion of sites across the state to include 13 urology practices, that 80 out of 100 counties in the state have participated with client referrals, the annual number of procedures performed has tripled in the past 6 years, and the target population has been served. We know that 50% of our clients receive this quality service at no cost to them, meaning they are at or below 100% of the federal poverty level.

Lessons Learned:

If quality services are made available, people will seek you out. Low-income men are receptive to permanent sterilization. If you run your program efficiently, physicians will seek you out to become providers. Quoting from "Contraceptive Technology 17th Edition," "in a recent study, vasectomy was found to be the most effective contraceptive method of the 15 methods available in the United States."

Lead Poisoning Prevention and Education Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Community perceptions of health problems/needs Tracking Systems Population surveys (BRFS, PRAMS, PedNSS, YRBS) Environmental Assessments Hotlines, print materials, media campaigns Culturally appropriate health education Assessment of provider reports regarding process and outcomes Prepare, publish & distribute reports Public advocacy for legislation & resources Promotes compatibile, integrated service system initiatives Consistent, coordinated policies across programs MCH legislative activity Provide infrastructure/capacity for MCH functions Staff Training Support of continuing education Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity	Home visiting Lead poisoning Schools & health connections Strategic planning Reshaping urban MCH Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, General state funds, Other Federal funds

Budget: $150,000.00

Description:

The Hartford Health Department (HHD) assumed a leadership role in development of a comprehensive Lead Poisoning Prevention and Education Program, working to eliminate pediatric lead exposure, and established infrastructure within the community.

Objectives of the activity:

Assure timely environmental investigations are performed on all confirmed cases of elevated blood lead levels; assure an epidemiological inspection is conducted and an environmental inspection is conducted upon notification of a child with an elevated blood lead level. Assure abatement and/or management is being performed at all sites where a child (under 6 years) with a high blood lead level resides and toxic levels of lead have been identified; issue enforcement actions necessary to ensure abatement of the identified sources of lead and relocate individuals with lead poisoning where necessary. Assure that educational materials and guidance on lead poisoning prevention strategies, nutrition, housekeeping, current laws, and other interventions to reduce exposure to lead are available upon request; parents of children with confirmation levels ≥10 ug/dl receive educational material and parents of children with confirmed blood lead levels >19 ug/dl receive individual counseling.

Barriers encountered in implementation:	Strategies to overcome barriers:
The legislature passed the Childhood Lead Poisoning Prevention and Control Regulations without appropriating any additional dollars to local communities. Accurate and reliable data on lead poisoning is not available. Business interests versus child health advocates. Lack of infrastructure at the local level to handle issues surrounding lead poisoning. Lack of provider network for referrals. Lack of treatment center for children and families. Social service agencies providing limited assistance. Limited resources for relocation. Other than shelters, no temporary safe havens for families and children. Lead safe housing for children is non existent. Insufficient contractors/workers/site supervisors trained in appropriate lead remediation. No financing to property owners for performing abatement work. Enforcement mechanism limited. Limited community partners. Educational awareness programs not in place. No comprehensive care document for health care providers.	The State provided financial resources to local health departments. HHD received funding from several federal agencies, and works with the State CLPPP program to refine childhood lead surveillance data. A Task Force was convened to discuss differences and improve working relations. The Hartford Regional Lead Treatment Center acted as a network for providers and as a referral source for neighborhood clinics physicians. The DSS provides case management for children with elevated blood lead levels and temporary relocation expenses. The Hartford Regional Lead Safe House provides temporary shelter. The State funded training programs for contractors, workers and site supervisors. The City received $2.5 million to provide property owners with grants to perform lead hazard control work. The State Department of Economic and Community Development provided funding to local CAP agencies to provide monies to property owners. The City partnered with the Housing Prosecutors office to gain compliance. The HHD applied for additional funding to develop educational awareness campaigns, partnered with the State CLPPP and other agencies to develop a Comprehensive Care Document for practitioners and physicians.

Role of health department in implementation, planning, and evaluation:

The HHD has provided data and staff resources to this collaborative initiative. The HHD's role has been to provide assessment, assurance, environmental remediation, case management and policy development relating to the elimination of childhood lead poisoning in our community.

Accomplishments:

This Program has been recognized by the State of Connecticut as exemplary. Over 150 housing units have been made lead safe and an additional 50 units will be lead safe by January 2001. The Hartford Lead Safe House has served 87 families with 257 children since 1994. Annually, 40-60 individual properties containing lead-related housing code violations are brought to prosecution; 30% come back into compliance. The HHD and the University of Connecticut conducted lead poisoning prevention awareness training for 110 child care providers. The HHD collaborated with the State Health Department in the "Keep it Clean Campaign," a statewide educational outreach partnership with local paint and hardware stores. The HHD partnered to develop an educational message placed on milk cartons during May 2000. Hartford and the State Department of Public Health coordinated a children's artwork display. The HHD's "A Perfect Partnership-Lead Poisoning Prevention Video" has been distributed to Hartford Public Library sites for distribution and has been aired on Public Access TV. Educational messages appeared in English and Spanish on Connecticut Transit Municipal Bus Service, Bus Shelter signage, and local billboards. A partnership between the HHD and Housing Departments, the UNCONN Cooperative Extension Program and The Hartford Public Schools designed an activity booklet for children regarding the hazards of lead for use in fall 2000.

Lessons Learned:

Coordination and collaboration have been key to program success. Broad-based coalitions of health professionals and community agencies have joined to produce a comprehensive, coordinated and effective program.

Hawaii Childrens Trust Fund

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Prepare, publish & distribute reports Public advocacy for legislation & resources Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity Identify & report access barriers Eliminating social disparities, supporting fatherhood	Injury (including child abuse) Overcoming cultural barriers Expanding private sector links Strategic planning Building coalitions & partnerships

Funding Sources:
Private source(s): In-kind private funds, Other Federal funds, Other: In-kind state funds

Budget: $450,000.00

Description:

The Hawaii Childrens Trust Fund (HCTF) is a permanent endowment fund that provides grants to strengthen families, prevent child abuse and neglect and promote the healthy development of children. This private-public partnership combines the resources of government and the private sector. The fund is managed through the Hawaii Community Foundation (HCF), a statewide grant making foundation with considerable assets. Both the HCF and the MCHB/DOH provide staff support to this effort to assure success. Grant making activities are supported through both the combined energy of the HCTF Advisory Board and Committee. Current grants are funded through the Community-Based Family Resource and Support Grant Program, a federal grant secured by the MCHB/DOH.

Objectives of the activity:

1. Assure collaboration with other statewide planning efforts around family strengthening programs through active interagency networking, partnerships, and agreements. 2. Identify, establish and perpetuate funding resources for family strengthening programs that prevent child abuse and neglect. 3. Provide agencies with skills to increase capacity for self-evaluation through training, peer mentoring and other activities. 4. Increase community involvement in resolving problems/ issues faced by children and families through broad-based community participation. 5. Support the development of model family strengthening programs that prevent child abuse and neglect by providing funding opportunities.

Barriers encountered in implementation:	Strategies to overcome barriers:
Ongoing fund development to meet endowment goal of five million. Poor state economy has limited contributions and participation of potential funders.	Continue public awareness, increase membership in coalition of agencies to promote support and regroup and reassess fundraising efforts.

Role of health department in implementation, planning, and evaluation:

The Maternal and Child Health Branch (MCHB)/Department of Health provides the oversight and staff support necessary to obtain grant funding, leverage funds for federal grant, hire and supervise staff person, participate in and staff Hawaii Children's Trust Fund Advisory Board, Advisory Committee and Coalition and other activities necessary to manage the problem.

Accomplishments:

1. Private-public partnership at corporate level. 2. Legislatively established. 3. Permanent endowment fund established. 4. Yearly grant-making to community-based programs; over 12 agencies funded over past three years. 5. Ongoing needs assessment and planning. 6. Training provided to funded agencies, staff on outcomes and evaluation.

Lessons Learned:

High level support and commitment needed for successful partnership. Neither public or private sector can do it alone--Child Abuse and Neglect is a community issue that demands community involvement. The state of the State's economy affects grant-making and fundraising.

Indianapolis Healthy Babies

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Tracking Systems Maternal, fetal/infant, child death reviews Prepare, publish & distribute reports Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Provide infrastructure/capacity for MCH functions Identify high-risk/hard-to-reach populations & methods to serve them Identify & report access barriers	Preconception promotion Prenatal care Low birthweight/infant mortality Teen pregnancy Building coalitions & partnerships Building MCH data capacity Infant/child death review

Funding Sources:
City/County/Local government funds, Private source(s): Area For Profit Hospitals

Budget: $93,000.00

Description:

Area hospitals will conduct a consistent and continual review of their fetal and infant deaths in partnership with the Indianapolis Healthy Babies (IHB) of the Marion County Health Department. A Medical Abstractor, employed through IHB, will perform monthly abstracts on the fetal infant deaths at each hospital. NFIMR data abstraction forms will be used for this process. Each area hospital will form an internal review team to review the data in coordination with IHB staff. Quarterly reports addressing fetal and infant mortality and morbidity will be produced by IHB and distributed to all area hospitals and other interested parties of Marion County. Both medical and social issues will be addressed.

Objectives of the activity:

The objective of this activity is to look at the county's fetal and infant mortality and morbidity over a continual period of time. Its focus will be to see if and what types of trends exist within the community socially and professionally that effect fetal and infant mortality and morbidity. The data collection will include the review of thirteen forms, which provide detailed assessments.

Barriers encountered in implementation:	Strategies to overcome barriers:
IHB has a consortium component of approximately 140 volunteer members. Some of these members are area physicians. These physicians were able to provide IHB with the appropriate names to contact at the hospitals.	The greatest barrier facing implementation has been coordinating schedules and getting to the appropriate hospital administrators. Once the appropriate individuals were contacted, they were willing to participate.

Role of health department in implementation, planning, and evaluation:

Indianapolis Healthy Babies (IHB) is a program within the Marion County Health Department. IHB planned the FIMR project by outlining the purpose, the staffing needs and the project's financial needs of FIMR. IHB will implement FIMR out of the Marion County Health Department with additional financial support from all area hospitals. This process will be done over a consecutive five-year period. All area hospitals and the Marion County Health Department will be involved in the evaluation process.

Accomplishments:

All area hospitals have committed to the project. Meetings are currently being held to create memorandums for each hospital.

Lessons Learned:

We underestimated the amount of time the negotiations would take. The area hospitals were very willing to work in partnership to reduce fetal and infant mortality.

"Get Hep B" Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Hotlines, print materials, media campaigns Culturally appropriate health education Prepare, publish & distribute reports Promotes compatibile, integrated service system initiatives Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify & report access barriers	Immunizations School-linked/based services Schools & health connections One-stop shopping locations Other outreach activities Securing MCH assistance Immunization tracking/recall

Funding Sources:
City/County/Local government funds, General state funds, Private source(s): In-kind contributions of staff time and supplies from local area hospitals, Other Federal funds,Third party reimbursement (Medicaid, insurance)

Budget: $466,422.00

Description:

This is a school-based immunization program to protect all area sixth graders from contracting Hepatitis B. This program is sponsored by the Mid-America Immunization Coalition in conjunction with local health departments, area hospitals, and public/private school districts. The total number of sixth graders enrolled exceeded 18,000, with just under 13,000 returning the consent form.

Objectives of the activity:

1. Immunize 70% of all eligible and enrolled sixth graders in Kansas City Metropolitan Area. 2. Elicit a 50% completion rate for all children consented to participate.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Heavy coordination with school districts, health departments and staff. 2. Short or accelerated timeline of immunizations. 3. Amount of staff time to plan, give shots and record information in database. 4. Bi-state/multijurisdictional efforts.	The only way to overcome these barriers is to start planning for the next as soon as you can. High levels of communication and coordination must occur with over 100 agencies and schools to maintain the project. Planning/Scheduling are key.

Role of health department in implementation, planning, and evaluation:

We have played a major role in developing and cultivating relationships with the Kansas City, Missouri, school district to allow the immunizations to take place. We have also participated as a direct service provider of the shots to over 20 schools.

Accomplishments:

1. 84% consent rate (parental approval/declination for shots). 2. 90% of consentees gave approval to receive the shots. 3. 75% (11,108) of consentees received all three doses. 4. $5.06/cost per dose (includes volunteer/in-kind contributions) 5. $25 million in future health care costs were prevented by vaccination.

Lessons Learned:

Early planning and coordination with school districts is a must. To get all three shots done before the end of school requires extensive planning. Marketing of project helped to contribute to cooperation and parental participation.

Quick WIC

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Has this activity been formally evaluated?
Don't know

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Culturally appropriate health education Promotes compatibile, integrated service system initiatives Provide, arrange, administer direct services	Breastfeeding/nutrition/WIC Violence prevention/at risk

Funding Sources:
City/County/Local government funds, Other: U.S. Department of Agriculture through the State of Tennessee Department of Health

Budget: Not specified

Description:

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in Know County inplemented Quick WIC in January of 2000. Quick WIC provides services to groups of low-risk participants who do not need their height, weight, and hemoglobin measurements taken during their visits. Quick WIC is held weekly in our Nutrition Education Center on Monday, Wednesday and Friday, eliminating the need for participants to report to the WIC clinic. The Nutrition Education Center consists of a fully equipped demonstration kitchen and a mock grocery store. In the Nutrition Education Center, Quick WIC participants register for their appointment, participate in a group nutrition education, and receive vouchers. The process requires that a nutrition educator and a voucher clerk be available in the Nutrition Education center during the scheduled Quick WIC times. The nutrition education is presented in an interesting format that encourages the participation of the group. A computer is available for participants to play informative nutrition games using Pryamid Explorer Nutrition Adventure Program. During the summer months, Quick WIC participants receive fresh produce from Beardsley Community Farm, an urban agricultural center that provides learning opportunities and fresh produce to low-income families. The entire Quick WIC process takes approximately twenty minutes for participants to receive services, reducing waiting time by more than half. Based on client feedback, participants are very happy with the efficient services and the nutrition activities provided by Quick WIC.

Objectives of the activity:

The objectives of Quick WIC are to 1. reduce participants waiting time for WIC services by providing efficient services to low-risk participants in a group setting, 2. increase participants' utilization of the nutrition education center, 3. improve participant satisfaction with WIC services, and 4. improve the participant show rate for appointments.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Obtaining the support and commitment of WIC staff to make Quick WIC a success. 2. Informing participants about Quick WIC. 3. Scheduling low-risk participants for Quick WIC. 4. Participants arriving very early or late for their Quick WIC appointment. 5. Identifying the need for and providing immunizations to Quick WIC participants.	1. Involving WIC staff in the planning and problem solving of Quick WIC, discussing the benefits of Quick WIC, and having the support of supervisory and administrative staff. 2. Marketing Quick WIC to participants through posters, handouts, invitations, and communication from the WIC staff as well as word of mouth from Quick WIC participants. 3. Educating WIC staff of the criteria required for participants to attend Quick WIC and the need to schedule participants for the appropriate Quick WIC session. 4. Informing participants that Quick WIC begins as scheduled, enforcing the schedule, and posting the schedule outside of the Nutrition Education Center. 5. Identifying participants needing immunization prior to Quick WIC, informing participants of need for immunizations, and offering immunization in the WIC clinic.

Role of health department in implementation, planning, and evaluation:

Quick WIC is based in the Nutrition Education Center at the Knox County Health Department. WIC had developed a referral network with other programs in the Health Department in a collaborative effort to improve the maternal and child health of those we serve. Key Partners/Collaborators: Tennessee Consumer Education Program (TNCEP) provides money to purchase items for food demonstration during Quick WIC. Beardsley Community Farm provides shares of fresh vegetables that are given to Quick WIC participants. UT Agricultural Extension Service provides a variety of nutrition education handouts that are distributed to Quick WIC participants.

Accomplishments:

Quick WIC successfully reduced the amount of time required for participants to receive services and dramatically increases the utilization of the Nutrition Education Center. Currently, data is unavailable to determine Quick WIC has had a positive outcome on participant satisfaction but it will be collected later this year. However, Quick WIC evaluation forms indicate that participants are very happy with the services offered. To date the participant show rate has not improved.

Lessons Learned:

Successful implementation of Quick WIC requires a collaborative effort among staff, supervisors, and administration with agencies within the community to offer a successful program that benefits all who are involved.

"Spread the News About Folic Acid" Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Maternal, fetal/infant, child death reviews Culturally appropriate health education Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Prepare, publish & distribute reports Staff Training Provide, arrange, administer direct services	Preconception promotion Family Planning Prenatal care Staff training Strategic planning

Funding Sources:
General state funds

Budget: $67,584.00

Initially $46, 331 in June 2000: After this report was submitted, State funding changed for FY 2000-200 to $62,004.00. Medicaid--$5,580.00.

Description:

To provide 5,400 females of childbearing age with folic acid supplementation and counseling regarding the importance of folic acid and supplementation to reduce the incidence of neural tube defects. This service will be provided for all center users of childbearing age seen on-site at the Health Department for Family Planning, WIC, maternity (First trimester prenatals) and at off-site WIC clinics. The services will be provided primarily by Public health nurses and nutritionists.

Objectives of the activity:

To have zero center users with pregnancy outcomes resulting in neural tube defects which can be prevented with folic acid counseling and folic acid supplementation.

Barriers encountered in implementation:	Strategies to overcome barriers:
Obtaining enough bottles of multivitamins with 0.4 mg of folic acid to meet the demand upon implementation of the project. Also, finding the time to attend the training session and provide staff training within a very short time frame, and immediate implementation of the preliminary phase of the project in order to provide the State Department of Public Health preliminary data to project the folic acid supplementation and counseling utilization rate for our agency.	The Health Department Pharmacist contacted several pharmaceutical companies until enough bottles of multivitamins with 0.4 mg of folic acid were obtained and available to serve the projected number of childbearing women upon implementation of the project.

Role of health department in implementation, planning, and evaluation:

To coordinate the project with staff in Primary Care/Clinical Services and the Nutrition and Health Education Divisions. To establish in-house procedures for implementation of the project for clinics on-site and off-site which serve all women of childbearing age. To attend the state training session "Spread the News About Folic Acid Training," so that I could come back to the health department and train Primary Care and Clinical Services nurses. The MCH Nutrition Director trained the nutritionists.

Accomplishments:

Getting staff trained and obtaining enough bottles of multivitamins with 0.4 mg of folic acid to serve the projected number of childbearing women upon implementation of the project within a very short time frame.

Lessons Learned:

The project has only been in progress approximately two months. Lessons learned will be better evaluated in six to twelve months. More data will be available then to respond to this issue regarding lessons learned.

Improving Prenatal Smoking Cessation Outcomes in a Home Visit Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Implement public MCH Program client data systems Consistent, coordinated policies across programs Identify high-risk/hard-to-reach populations & methods to serve them	Prenatal care Home visiting Building MCH data capacity

Funding Sources:
MCH block grant funds, Other: Local tax funding

Budget: Not specified

Description:

In 1999, the Lincoln-Lancaster County Health Department decided to engage in a project to assure that all pregnant women coming in contact with direct service employees would get the same smoking cessation message. A committee was formed, curricula selected and staff training completed. During this preparation time, an evaluation of the public health nurse home visitation program was done to obtain a baseline on how effective current efforts were in curtailing smoking behaviors among the high risk women enrolled in the program. A chart review was completed on 55 women (closed cases) who received home visitation services using the prenatal care pathway.

Objectives of the activity:

This activity had one objective: To establish baseline measures of the proportion of pregnant home visitation clients who never smoked or who stopped smoking during their pregnancy.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier was the time it took to extract the information from client charts. Another issue is that this evaluation was limited to clients who were visited long enough to achieve at least one of the prenatal care objectives. An evaluation was not done on those who dropped out of care or moved before progress was made. The issue of moving is important because we have identified a population of young women in fragile living situations who move outside the county in hopes of being lost to service (no visitation programs in the surrounding counties).	Within the next 18 months, the agency will begin using a new electronic client record system which has been custom programmed to track the outcomes from the prenatal care pathway. This new system will allow for a much broader collection of date at a fraction of the cost.

Role of health department in implementation, planning, and evaluation:

Key Health Department staff took the leadership in this project. Others who are working with us on the tailored smoking message are the American Cancer Society, Lincoln Medical Education Foundation, Family Practice Residency Program and the Lancaster County Medical Society.

Accomplishments:

The audit tool was developed with volunteers from the home visitation staff. Three sessions were held to assure that each reviewer was obtaining reliable results. Once the data was collected and analyzed, the Quality Improvement Coordinator presented the findings to the public health nurses and health educators. The fact that the original intervention was successful in obtaining lower smoking rates than found in the general population inspired new enthusiasm among the public health nurses and a sense of optimism that this was an area where they could improve outcomes for prenatal care.

Lessons Learned:

Usually you expect these projects to yield poor results. In this case staff were pleasantly surprised at how effective they were in motivating mothers to stop smoking. Their perceptions were that it "wasn't making any difference" or "nothing works." The baseline information gave staff a renewed desire to work even harder to prevent in-utero and perinatal exposures.

Prenatal Record Card for Moms

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Tracking Systems Maternal, fetal/infant, child death reviews Hotlines, print materials, media campaigns Promotes compatibile, integrated service system initiatives Identify & report access barriers	Prenatal care Low birthweight/infant mortality

Funding Sources:
City/County/Local government funds

Budget: Not specified

Description:

During our Infant Mortality Review Team meetings we realized that women were presenting to deliver without their prenatal records. Most records are carried or faxed to the hospital by the private MD's or by the health unit at 28 weeks gestation. If a woman goes to the emergency room or labor and delivery in preterm labor, especially at night, the hospital has no way to contact the various clinics for copies of the record.

Objectives of the activity:

To prevent this problem, a Mini-Prenatal Record was designed on card stock paper. All lab work, pertinent medical history and EDC were placed on this record by the clinic nurse. The record is small enough to be kept in the patient's purse or wallet. If an emergency occurs, this record prevents unnecessary duplication of lab work and added cost to the patient. It also has all the basic information for the Labor and Delivery Staff and delivering doctor. For the mom to be, we included the signs of preterm labor on the back of the prenatal mini-record.

Barriers encountered in implementation:	Strategies to overcome barriers:
Deciding what the minimum information needed to be was of value to the delivering doctor. Printing record on card stock paper that was available and strong enough to be carried around by the patient for several months in her purse. Convincing clinic staff on the importance of filling out another piece of paperwork.	1. Discussion was held at the IMR Case review team meetings on what to include on Mini-Record. The finished product was reviewed by a private OB/GYN and our Perinatal Health Staff at the AR Department of Health. 2. Form was made on cardstock paper—you can print two to three minirecords per page. 3. Discussing reason for the need of the record at area nursing meetings; then they realized the record would most often only have to be filled out one time, when the patient's lab was completed. Records are also given out at health fairs for mothers to take back to their own doctor for use in their private practice.

Role of health department in implementation, planning, and evaluation:

This record was designed by our local Infant Mortality Review team which is a part of our health department. It was then presented to a statewide meeting of other Health Department Infant Mortality Review team members and the Maternal Child Health Specialist. The minirecord then was made available for use in local health department clinics across the state.

Accomplishments:

Having this simple idea designed in one area of the state and then being used statewide has been a major accomplishment.

Lessons Learned:

It doesn't have to cost a lot of money to make positive changes if everyone works together toward a common goal.

Perinatal Outreach and Education Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Culturally appropriate health education Implement/support education services for special MCH problems Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them	Preconception promotion Family Planning Prenatal care Immunizations EPSDT/screenings Overcoming cultural barriers Other outreach activities Increasing social support Increasing access to Medicaid

Funding Sources:
City/County/Local government funds, Private source(s): Pacific Hospital of Long Beach Charitable Trust

Budget: $36,390.00

Description:

The project provided classes, preventive health screenings, and health care referral linkages, to low-income Spanish-speaking Latina women living in two targeted zip codes. A series of five classes were provided by a Spanish-speaking health educator at four community sites (a police community center, a school parent center, and two social services centers). The classes were based on the March of Dimes "Comenzando Bien" curriculum, which was expanded to cover additional perinatal and family health topics requested by the attendees. Women were recruited from the community to provide outreach and assistance with the classes. These women were trained to act as resources and promote utilization of preventive and primary health care resources. The women received stipends. Health screenings for diabetes, anemia, hypertension, TB and immunizations were provided for the women and their families by the health department nurse, who also tracked and followed up on receipt of health care for identified problems.

Objectives of the activity:

The objective was to involve a minimum of 75 Spanish-speaking women of child-bearing age residing in the targeted zip codes in the program. By the end of the program, participants will have received health screening, and will be able to: 1. Name five health care resources in their community; 2. Express positive attitudes regarding the receipt of preventive health care; 3. Establish contact with referral resources for health care; and 4. Commit to distribution of health resource information in their neighborhoods.

Barriers encountered in implementation:	Strategies to overcome barriers:
Several barriers were identified, most of which are common to this type of outreach/education program: 1. Advertising/Attendance—close coordination was needed to be maintained with the agency sites in order to ensure adequate publicizing, which was necessary to maximize attendance; 2. Child care—It was needed, but not planned for in the application proposal; 3. Fixed curriculum—didn't always cover what participants were most concerned about; 4. Time Limitations—sessions were too short to cover everything.	1. To increase attendance, incentives were offered, and convenient times and locations were used. Tapping into groups that already existed (such as ESL classes) worked well. Agency sites were assisted with advertising—i.e., fliers were provided; 2. Families were allowed to bring children—which presented another barrier. Stipend money was used to pay for child care on-site; 3. Items were added to the curriculum based on participant input and suggestions; 4. The instructor remained on-site after concluding the presentation in order to answer questions.

Role of health department in implementation, planning, and evaluation:

Health department staff (Nursing Division) were responsible for all aspects of the planning, implementation and evaluation of the project.

Accomplishments:

The targeted number of participants (75) was exceeded. A total of 182 women residing in the target zip codes were reached, and 130 women completed the series of five classes and graduated from the program. Written and oral evaluation was conducted with all participants. They were able to demonstrate proficiency in and commitment to the four objectives. Several of the women strongly embraced the program, and were instrumental in expanding the program to a fourth site (three were originally planned). Two of the women went on to work for other outreach and "promotora"--type Health Department programs.

Lessons Learned:

1. There is a definite and ongoing need in the underserved community for education regarding health care and resources; 2. Obtaining buy-in from the on-site agencies is essential; 3. Don't assume your curriculum is what is wanted or needed--be flexible.

Esperanza Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Implement public MCH Program client data systems Culturally appropriate health education Implement/support education services for special MCH problems Staff Training Provide outreach services Transportation & other access-enabling services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Family Planning Prenatal care Expanding maternity services Home visiting Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunizations Early intervention/ZERO TO THREE EPSDT/screenings Expanded child health services Injury (including child abuse) Violence prevention/at riskTeen pregnancy Teen parenting Family Violence Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Other outreach activities Increasing social support Case coordination Increasing access to Medicaid Staff training Building coalitions & partnerships

Funding Sources:
Private source(s): Other Federal funds, Other: Proposition 99 Tobacco Products Surtax Funds

Budget: $350,000.00

Description:

In 1996-1997, Los Angeles County was chosen by the U.S. Department of Justice as one of six pilot sites to replicate the Prenatal and Early Childhood Nurse Home Visitation Program. Our replication project, entitled Esperanza Project, began in October 1997. The project focused on the Pico-Union/Westlake district of Los Angeles and was a public/private cooperative endeavor with the California Hospital Medical Center's (CHMC's) Hope Street Clinic, a family resource center serving the target population. Four county-funded public health nurses were located at CHMC and were charged with the responsibility of identifying 100 first-time pregnant, low-income, Hispanic women younger than 26 years of age, and with providing them with home visitation, education, and case management through pregnancy and the first two years of the infant's life.

Objectives of the activity:

Developed by David Olds, PhD, of the University of Colorado, the Prenatal and Early Childhood Nurse Home Visitation Program was first implemented in Elmira, NY nearly 20 years ago and was subsequently replicated in Memphis, TN. Its major goals were to improve pregnancy outcomes; promote children's health and development; and strengthen families' social functioning and economic self-sufficiency. Documented benefits from these studies include reduction in: child abuse and neglect; subsequent unintended pregnancies; use of welfare; childhood injury and ingestions; substace abuse; unemployment; and involvement in criminal behavior. By the time their children were 15 years of age, the children had fewer arrests and convictions, smoked and drank less, and had fewer sexual partners. Copious data regarding both short-term and long-term impact were collectd for the project and were the same for all six replication sites (although fewer effects on birth outcomes or on children's short-term development have previously been documented, except for children born to women who smoked cigarettes when they registered during pregnancies). Data was collected and analyzed at the University of Colorado for all replication sites.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Melding expectations of public and private partners for the project. 2. Supporting and encouraging staff in performance of new roles; creating and maintaining a new organizational culture. 3. Maintaining accurate and timely collection and transmission of data. 4. Recruiting and maintaining patients in the study. 5. Managing high expectations for the project before data are completely collected and analyzed.	1. Active management meetings with partners, and development of trust and mutual interdependence of partners. 2. High level and supportive staff supervision. 3. Installation of new and better database programs. 4. Replacement of lost and "graduated" participants; publicity and "word-of-mouth" have increased the project's stature and prestige in the community. 5. Careful balancing of the benefits of publicity with the risks of inflated expectations.

Role of health department in implementation, planning, and evaluation:

Planning: Important for developing public/private partnership; negligible for protocol development. Implementing: Role of health department has been primary. Evaluating: Minimal; University of Colorado has taken primary role.

Accomplishments:

1. Low rates of attrition during pregnancy and through the child's first birthday. 2. Strong evidence of program fidelity to the original model; slightly higher mean number of visits completed during pregnancy and infancy stages of the program than observed for aggregated data from all six sites and Denver. 3. Higher rates of mothers reporting no emergency room visits or hospitalization through six months of age than that observed for aggregated data from all six sites.

Lessons Learned:

1. Public/private partnerships can work very well! 2. Carefully developed research projects can be replicated with patient populations of difficult races/ethnicities. 3. It is difficult to manage the expectations of the public, interested parties, and the media. 4. It will be some time before we know if the Esperanza Project has successfully replicated findings of Olds' earlier studies.

Healthy Families

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Has this activity been formally evaluated?
Don't know

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Implement public MCH Program client data systems Analysis of demographics, economic status, behaviors, health status Tracking Systems Culturally appropriate health education Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Public advocacy for legislation & resources Promotes compatibile, integrated service system initiatives Provide infrastructure/capacity for MCH functions Staff Training Support of continuing education Transportation & other access-enabling services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand system capacity Identify & report access barriers	Preconception promotion Family Planning Home visiting Immunizations Early intervention/ZERO TO THREE EPSDT/screenings Injury (including child abuse) Teen pregnancy Teen parenting Family Violence Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Clergy & health connections Schools & health connections One-stop shopping locations Increasing social support Case coordination Staff training Reshaping urban MCH Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, General state funds, Other Federal funds, Third party reimbursement (Medicaid, insurance)

Budget: $400,000.00

Description:

Healthy Families is a voluntary intensive home visitation program that offers support services to overburdened families who are expecting a baby or who just had a newborn. These support services are carried out by the Family Support worker whose main goals are to work with the families to promote positive parent-child interaction, promote healthy childhood growth and development and to enhance family functioning. Healthy Families is a prevention program based on recent brain development research which emphasizes the importance of the first years of a child's life which is crucial in a child's learning to trust and develop attachments. Services are provided through a contract with Family and Children's Counseling Centers, Inc., an established private agency that offers counseling, education, and case management to families, couples, and individuals.

Objectives of the activity:

The program objectives are: 1. Children enrolled in Healthy Families will have up-to-date immunizations. 2. Children enrolled in Healthy Families will be developmentally on target. 3. Children enrolled in Healthy Families will be free from child abuse and neglect. 4. Parents will demonstrate competency in the parenting of their children.

Barriers encountered in implementation:	Strategies to overcome barriers:
Understanding and integrating organizational cultures of health and human service agencies to achieve effective partnership	1. Ongoing communication regarding management issues as well as structured team-based triage and integrated service meeting 2. Ongoing search for additional funding

Role of health department in implementation, planning, and evaluation:

There are two service components to Healthy Families-Assessment and Home Visitation. The Health Department screens their prenatal patients at various clinic sites and offers in-home assessments to families who screened positive. The assessment process allows us to identify families who are overburdened and in need of home visitation services.

Accomplishments:

1. Record integration 2. Positive outcomes for families 3. Additional funding through Healthy Start

Lessons Learned:

Working through organizational culture issues should be a programmatic priority.

Safe Nursery Action Group

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Implement/support education services for special MCH problems Public advocacy for legislation & resources	Injury (including child abuse) Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, General state funds, MCH block grant funds

Budget: Not specified

Description:

It began with an e-mail from our state health department that yet another child had died in a recalled portable crib. This was followed by a heart-wrenching e-mail from Danny's parents, asking for help in telling parents and other child care providers about dangerous nursery equipment. The Madison Department of Public Health (MDPH) responded to the plea by calling together a group which became the "Safe Nursery Action Group of the Madison Area SAFE KIDS Coalition." Joining the MDPH Public Health Nurse, Health Educator and MCH Specialist were the County Health Department Health Educator, the SAFE KIDS Coalition Coordinator, a State Consumer Protection Product Safety Investigator and a March of Dimes representative.

Objectives of the activity:

The primary objective is to increase awareness with resultant behavior change regarding the continued use, sharing and resale of dangerous nursery items and clothing, in order to prevent further injury and death of children.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier is a financial one. Regarding behavior change, those purchasing used equipment do so because they cannot afford the new and those selling, do so to make money. Because this project has no separate funding, all involved must try to fit activities into their existing workload. In addition, there is sometimes an attitude barrier: "We used it with our baby and nothing happened, so what's the big deal?"	All financial barriers could be overcome by finding a funding source to: provide free or low cost safe cribs to families with financial limitations, purchase unsafe equipment from sellers and destroy it, and fund a position to spend more time on action group activities. In the meantime, we will continue to address the ignorance and attitude barriers by distributing information about potentially dangerous children's clothing and nursery items.

Role of health department in implementation, planning, and evaluation:

The Madison Department of Public Health took the lead in bringing together others interested in this initiative. Eventually it became an Action Group of the Madison Area SAFE KIDS Coalition. The MDPH Public Health Nurse, Health Educator and the Maternal-Child Health Specialist have been active members of the group.

Accomplishments:

The public awareness initiative began with notification sent to local child care providers organizations and to the state medical society, requesting that they inform their members of the continuing threat presented by dangerous nursery equipment and informing them of available educational materials. A display was developed and taken to numerous community events. The next target was resale shops and organizations that offer baby items to families with limited income. A Consumer Product Safety Commission (CPSC) "The Safe Nursery" booklet and flier was sent to each shop and organization in the county, telling of the need to check nursery equipment for safety. One group of shops is doing safety checks on all donated nursery equipment and discarding dangerous items. One private "Sharing Center" has put together notebooks of information to help volunteers with the safety checks of donated items. Then we focused on those persons who have and/or shop at garage sales. We partnered with the local newpapers, which offered to publish a "Garage Sale Buyer Beware" PSA warning about old nursery equipment at the beginning of their garage sale classified section. They also included a flier in the garage sale packet sent to those placing ads, warning that the garage sale items they are selling could be deadly. This year the danger of children's clothing with drawstrings was included in the PSA and fliers. The most recent target is places of worship, which usually depend on donations of used equipment for their nurseries. Contacts have been made with a parish nurse organization, a new flier developed which will be distributed to the local faith community, and a diocese newsletter article will be appearing soon. Future plans include continued focus on the faith community as well as the hotel/motel industry. The SAFE KIDS Coalition recently held a media event related to unsafe cribs used by motels in a neighboring county tourist area.

Lessons Learned:

This is an excellent example of how city, county and state organizations, both public and private, can share resources and work together toward a common goal. It also demonstrated an unfortunate reality: the priorities of health professionals and child advocates are not always shared by those who need to make the changes.

Lead Poisoning Screening Guidelines for Miami Dade County

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
	Early intervention/zero to three EPSDT/screenings Expanded child health services Lead poisoning

Funding Sources:
Other Federal funds

Budget: Not Specified

Description:

Targeted screening recommendations focus efforts on at-risk groups to increase the probability of reaching children with lead poisoning. Prior to August 1999, there were no screening guidelines for Miami-Dade County. Local demographic data of lead poison cases reported to the program by zip code areas were plotted on a GIS map of the county. Local risk factors for lead poisoning as stated in the 1997 CDC publication "Screening Young Children for Lead Poisoning," were also presented in a GIS map of highlighted zip code areas with ≥ 27% of homes built before 1950. A Screening Guidlines Committee composed of representatives from: a local university-run clinic, a tertiary care hospital prediatric clinic, Medicaid area office, professors of public health at local universities and the Miami-Dade County Health Department, drafted screening recommendations from the above mentioned information and Medicaid requirements. The lead screening guidelines draft was presented to an advisory committee composed of representatives from various sectors of the Miami-Dade community. Once the Advisory committee approved the finalized guidelines, the epidemiologist of the lead program tested them for sensitivity and the lead program disseminated these guidelines to providers using the state licensing database.

Objectives of the activity:

The goal is to develop and promote lead screening recommendations for children age six and under in Miami-Dade County. The objectives are: by August 1999, develop local screening recommendations for Miami-Dade County. By June 2000, disseminate screening recommendations to 100% of primary care providers in Miami-Dade County. The evaluation of those objectives measured the level of achievement. The guidelines were produced and disseminated. In the future, the lead program will monitor sensitivity of those recommendations and the number of providers reached with those guidelines. In addition to measuring the increase of screening of children as a result of those screening guidelines and the increase of cases of lead poisoning reported to the program, the lead program will survey providers about the usefulness of those recommendations.

Barriers encountered in implementation:	Strategies to overcome barriers:
The program had to start from scratch with nothing to model after since screening guidelines for lead in Miami-Dade county has never been attempted before. The database of providers from the state licensing was not updated. Negative blood lead test results are not reportable by law, therefore prevalence is not known.	We collaborated with the state and modeled the format after the initial draft of screening guidelines developed from the state. We identified and secured collaboration of valuable partners from the state health department and the community. We are updating information on providers as guidelines mailed to providers listed on the database are returned to us. We will publish those guidelines in medical journals, newsletters and on the Internet. We are proposing legislation to require mandatory reporting of all blood lead levels.

Role of health department in implementation, planning, and evaluation:

We gathered, analyzed, and illustrated the data in GIS format. This data were disseminated to the screening committee. Once the guidelines were approved, the health department combined and presented the information in a usable format that modeled after ther state drafted guidelines. We disseminated the guidelines through various avenues.

Accomplishments:

The accomplishments to date are that we have guidelines available to help providers identify at risk children and a successful development of a partnership between the MDCHD and the community that is still active.

Lessons Learned:

Data is crucial in identifying at-risk population.

Healthy Learners Board Initiative

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Culturally appropriate health education Develop & promote MCH agenda & Year 2000 National Objectives Identify high-risk/hard-to-reach populations & methods to serve them	Immunizations School-linked/based services Overcoming cultural barriers Schools & health connections Increasing social support Increasing access to Medicaid

Funding Sources:
City/County/Local government funds, Private source(s): Partners on Healthy Learners $5,000-15,000 each, Additional funding-Children's Hospital fiscal agent

Budget: $1,000,000.00

Description:

In February 1998, Minneapolis Public Schools Superintendent Carol Johnson and Jim Ehlen, President of Allina Health System issued a call to substantially improve education outcomes through health improvement. The public/private partnership is known as the Health Learners Board (HLB). Currently there are 27 member organizations. The HLB vision is: We want all children in Minneapolis to enjoy optimal health and academic success. The mission is: The Health Learners Board exists to optimize health status and academic success of children through collaborative action between the Minneapolis Public Schools and community partners in health and business.

Objectives of the activity:

The "No Shots, No School" immunization initiative was the HLB's first program, and it is embarking on its third year. "No Shots, No School" has demonstrated two highly successful years of immunization rates by the end of the first week of school-97.6% in 1998 and 98.6% in 1999; the 1997 prior rate was 69%. The Welcome Center was created to give new students an unique opportunity to get connected to community resources. Registration for school is one of the first activities a family new to a community is involved in. Seventeen percent of all new students don't have English as a primary language. With the success of "No Shots, No School," a pediatric asthma initiative was begun in April of 1999. Both the lack of immunizations and asthma are factors related to school absenteeism.

Barriers encountered in implementation:	Strategies to overcome barriers:
Strategically aligning different organizational activities to achieve a common objective. (Establish relationships and plan collaboratively.) The Welcome Center is serving people who don't speak English. There is no way to predict immigrants. Now there is a steady flow of activity. There is a need to have adequate staffing to cover interpreters at private sites. We are getting more clients with culturally specific needs.	Ongoing data collection, document trends, flexible staffing, pooling of resources such as colocating with language staff to screen language problems, other resources dedicated to rigorous evaluation. Barriers are being overcome through the asthma initiative by bringing new learnings. If we can learn effective management of asthma, we can apply it to other issues.

Role of health department in implementation, planning, and evaluation:

Three Care Partners—schools, MDHFS, Children's Hospitals—serve as executive committee, and guide the work and the governance of the organization. Staff are historically and currently involved in implementation of activities/Welcome Center.

Accomplishments:

Achieving higher rate of immunizations. Solidifying ongoing engagement and commitment from public and private partners. Launching a second initiative. Changing daily practices of private sector providers.

Lessons Learned:

Maintaining is harder than initiating. Sustainability better with all partners involved. Campaign strategy - "No Shots, No School" - urgency - engaged people, very successful - rewarded people.

Neighborhood Nurse Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting	Family Planning
Implement public MCH Program client data systems	Home visiting
Community perceptions of health problems/needs	Breastfeeding/nutrition/WIC
Environmental Assessments	Children with special needs
Hotlines, print materials, media campaigns	School-linked/based services
Culturally appropriate health education	Violence prevention/at risk teen pregnancy
Implement/support education services for special MCH problems	Teen parenting
Public advocacy for legislation & resources	Family Violence
Develop & promote MCH agenda & Year 2000 National Objectives	Reducing transportation barriers
Newsletters, convening focus groups, advisory committees, networks	Expanding private sector links
Promotes compatibile, integrated service system initiatives	One-stop shopping locations
MCH legslative activity	Other outreach activities
Provide infrastructure/capacity for MCH functions	Case coordination
Staff Training	Increasing access to Medicaid
Support of continuing education	Staff training
Provide outreach services	Reshaping urban MCH
Referral systems, resource directories, advertising , enrollment assistance	Building coalitions & partnerships
Identify high-risk/hard-to-reach populations & methods to serve them	
Provide, arrange, administer direct services	
Universal newborn screening programs	
Review process for ped LT care admissions, CSHCN home services	
Identify alternative resources to expand system capacity	
Identify & report access barriers	

Funding Sources:
City/County/Local government funds, General state funds, MCH block grant funds, Other Federal funds, Third party reimbursement (Medicaid, insurance)

Budget: $760,000.00

Description:

Family-based home visiting has been a priority of MCCHD for decades, but with issue-focused funding, services had become fragmented, i.e., prenatal, at-risk newborn, children with special needs. Through planning and creative financing, MCCHD "went back to the future" and developed the Neighborhood Nurse Program. With a county the size of the state of Delaware, some of the "neighborhoods" are geographically large, sparsely populated, but have a recognized community center. The majority of neighborhoods are within or very near the city of Missoula. Initially staffing was comprised of five PHN's. By combining various categorical funding, local/state MCH dollars and accessing funding such as TANF Special Project, Safe and Healthy Schools, staffing has grown to nine PHN's, three social workers, one R.D. Home-based services have been further enhanced through joint planning and collaboration with other programs, for example Early Head Start and MSU College of Nursing.

Objectives of the activity:

Neighborhood Nurse Program goals are to: Closely connect PHN's with families in the neighborhood, enhance family based practice of home visiting, open an additional point of access to services, involve neighborhood leaders, advocates and families, communicate neighborhood status to policy makers, strengthen Public Health Nursing and its identity. Based upon Healty People 2010, home visiting service objectives are to: increase to at least 90% the proportion of pregnant women who receive prenatal care in the first trimester, increase abstinence from tobacco use by pregnant women to at least 95% and increase abstinence from alcohol, cocaine, meth, marijuana by 20%, increase to at least 90% the number of two year olds who have completed the basic immunization series, assure access to a medical home for all children and increase to 95% the number of children preventative health care (EPSDT guidelines).

Barriers encountered in implementation:	Strategies to overcome barriers:
First and foremost is that few funding sources are available for comprehensive family-based home visiting, although acknowledgment of the value, and documentation through research, is gradually increasing. Limited information or lack of recognition regarding skills and knowledge of public health nurses, including other providers and policy makers.	Communication with other agencies and policy makers through formal presentation; joint program planning with other agencies and interagency staff communication. Public information through media, including newspaper insert regarding community MCH needs and public health services. Recognizing and informing media of "newsworthy" MCH issues and the department role or response. Organization of an MCH Advisory Council to the Board of Health, including consumers and key professionals and agency representatives.

Role of health department in implementation, planning, and evaluation:

The Neighborhood Nurse Program was planned and implemented by MCCHD. Enhancement of the program, in areas of service collaboration with other agencies, has been guided by MCCHD with active participation by community partners. Evaluation of direct services by PHN's, social workers and registered dietician is through record review and assessment of data regarding each of the objectives. A client satisfaction survey is conducted annually.

Accomplishments:

With the Neighborhood Nurse initiating services prenatally, and the same PHN continuing home visits throughout early childhood, client satisfaction is improved and family progress and outcomes more fully recognized and measured. Each of the 9 PHN's has developed a monthly Family Health Day at a neighborhood or community site which includes a WIC Satellite Clinic, Medicaid/SCHIP Outreach Worker, and a special program such as immunizations or lead screening, prenatal class or Early Head Start parenting/play group. A Healthy Start Forum is under development to improve communication and sharing of expertise and resources among community providers serving prenatal and early childhood populations.

Lessons Learned:

Our most significant role is to be proactive in bringing programs together and marketing our own services.

Community Systems Development Grants

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting	Preconception promotion
Analysis of demographics, economic status, behaviors, health status	Expanding maternity services
Community perceptions of health problems/needs	Home visiting
Culturally appropriate health education	School-linked/based services
Implement/support education services for special MCH problems	Teen pregnancy
Development of models	Dental programs
Develop & promote MCH agenda & YR2000 National Objectives	Other outreach activities
Promotes compatibile, integrated service system initiatives	Case coordination
Provide infrastructure/capacity for MCH functions	Building coalitions & partnerships
Staff Training	Building MCH data capacity
Provide outreach services	
Transportation & other access-enabling services	
Identify high-risk/hard-to-reach populations & methods to serve them	
Provide, arrange, administer direct services	
Identify alternative resources to expand system capacity	
Comparative analysis of Health Care delivery systems	

Funding Sources:
MCH block grant funds

Budget: $300,000.00

Description:

Recognizing the changing model for public health services nationally, Alabama Department of Public Health (ADPH) is encouraging county health departments (CHD's) to take steps toward strengthening core public health activities including interagency collaboration, identifying the local roles in service delivery, developing local plans, and documenting activites toward systems development. The ADPH invest $300,000 annually of state MCH funds for selected county health departments to engage in the building of infrastructure for population-based services and communitty systems development using the model of essential MCH services. Under this springboard for the future, counties are selected based on a competitive request for proposals. Monitoring procedures assure accountability in this regard.

Objectives of the activity:

1. By April 1, 1999, recommend a process for allocation of Title V resources to CHD's in FY 2000 for population-based services and community systems development. 2. By October 1, 2000, recommend a set of indicators to allow counties to identify and assess their activities in implementing and monitoring systems of care for the MCH population. 3. By August 1, 2000, develop process of evaluation for the community systems grant process. 4. By November 1, 2000, prepare an evaluation plan that identifies indicators for each project, indicators for state level monitoring, and quarterly reporting.

Barriers encountered in implementation:	Strategies to overcome barriers:
In FY 98, CHD services were devastated by a series of personnel cuts affecting primarily the home health care system, but affecting all aspects of local services delivery. In addition, the shift of patients under the Medicaid PCCM model to private sector primary care homes decreased visits to health department clinics and decreased resources under the services delivery reimbursement model. Based on the experiences of the past two years, the difficulty in engagement of local county health departments in community systems development and their critical funding shortfall, plans for FY 01 will be changed to reflect the realities of engagement of county health departments in systems development.	Providing guidance and concurrent training gives motivation to the staff as they apply different, yet similar skills. Using the needs assessment process allows the local county health department to participate in the needs assessment process, gives health department staff the skills needed to apply for funds, and also achieves the product—the required five-year needs assessment. The revised effort maximizes resources by combining training and producing a required product.

Role of health department in implementation, planning, and evaluation:

In FY 99, the ADPH began investing $300,000 of state MCH funds annually for selected local county health departments to engage in the building of an infrastructure for population-based services and community systems development using the model of essential MCH services. To date, approximately 13 local county health department projects have been funded. All projects are funded for a minimum of two years. On the basis of experience gained in the 13 funded projects, the Request for Proposals (RFP) process will be further modified for phasing additional (remaining) counties into the systems development community-based planning and implementation process. Additionally, strengthening the skills, knowledge and capability of the county health department staff to provide essential MCH functions and facilitate the development of comprehensive systems of care for the MCH population is ongoing.

Accomplishments:

The most significant achievements of the project occurred through the direct funding of 13 community systems development projects. These projects assisted the ADPH in the development of collaborative activities with other key players in the provision of care for the MCH population. Major results related to the goal of the project have been positive. The ADPH anticipates transitioning from this production-based funding model for direct care MCH services to a RFP model to support county health departments' activities related to developing and strengthening core/essential public health functions. The community systems development grants have given the local county health departments a renewed interest in community systems development.

Lessons Learned:

Measurements used to assess progress toward meeting goals should focus on intermediate process measures. A primary challenge is retooling the public health work force to effectively address community-based MCH using the essential MCH functions. Another key challenge is to reshape the entire community's perception of the role of the local county health department. Changing the community's view of the health department from that of provider to that of catalyst for community systems development is paramount.

Success By Six Mobile Unit Clinic

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Implement public MCH Program client data systems Analysis of demographics, economic status, behaviors, health status Tracking Systems Develop & promote MCH agenda & YR2000 National Objectives Promotes compatibile, integrated service system initiatives Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify & report access barriers	Early intervention/ZERO TO THREE Expanded child health services Children with special needs School-linked/based services Dental programs Reducing transportation barriers Schools & health connections One-stop shopping locations Mobile Clinics for outreach Case coordination Building coalitions & partnerships

Funding Sources:
Private source(s): Bank of America

Budget: $500,000.00

Description:

The Success By Six Mobile Initiative consists of multidisciplinary screenings conducted by a team of medical providers from private and public agencies in Nashville. They travel to day care facilities, preschools, Head Start Centers and other locations in a mobile clinic. Children ages six months through five years are screened in the areas of health, dental, development, vision, behavior, speech/language, and hearing. Case management is provided to support and ensure parents' follow-through with securing appropriate intervention for identified problems so that each child will be able to reach his or her potential.

Objectives of the activity:

The goal of the Success By Six Mobile Initiative is to insure that all children succeed in school. Progress indicators consist of two types of instruments: The Kindergarten Entry Skills Checklist-Revised (KES-R) assesses the developmental level of children at the beginning and again at the end of the kindergarten year. The K-Screen is a tool designed and utilized by Metro teachers to rate their students' reading and mathematics readiness skills.

Barriers encountered in implementation:	Strategies to overcome barriers:
The task of case management was made much more difficult by a lack of technical support. A computer-aided tracking program, which would have allowed follow-up information to be input and accessed by the screening team and other providers, was proposed as a donation from a local computer consulting firm. That donation never materialized. In hindsight, that portion of the project was too important to neglect. It should have been funded.	Referrals to other programs are being mailed or hand-delivered. However, information from other providers about the outcome of these referrals has not been as easily obtained as we would like. This is making the task of gathering statistics very difficult. We are attempting to overcome these barriers, but we have not been completely successful.

Role of health department in implementation, planning, and evaluation:

Metro Health Department designed the original model for the initiative. Staff in the Children's Special Services Clinic designed an evaluation model based on a team approach to be housed within the health department. This original plan, which was designed in 1993, was modified several times over the next six years. When Metro Health Department (MHD) acquired a large mobile unit, the plan was modified to utilize the unit. When Bank of America offered funding, this plan was submitted. The first year of the grant, MHD provided the Mobile Unit, a driver, and an audiologist. This year, MHD is the lead agency providing coordination and two nurses as well.

Accomplishments:

In 1998/99 (the first year), 3,189 children were screened and 1,118 referrals were made. This year, we will surpass those numbers. We have also added a strong, case-management component to the program. Another partner, Tennessee Voices for Children, has been added in order to provide behavior screenings.

Lessons Learned:

The importance of case management/follow-up was not realized during the first year of the grant. The number of referrals was larger than anticipated. The task of case management was made much more difficult by a lack of technical support. A computer-aided tracking program was proposed as a donation by a hindsight, that portion of the project was too important to leave out. It should have been funded.

Healthy Community Church-Based Programs

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand system capacity	Breast/cervical cancer Breastfeeding/nutrition/WIC Violence prevention/at risk Overcoming cultural barriers Clergy & health connections Other outreach activities Increasing social support Building coalitions & partnerships

Funding Sources:
General state funds

Budget: $60,800.00 Collaborating agencies supply many of the educational materials related to their health modules.

Description:

The Healthy Community Church-Based Program encourages healthy lifestyles in Orleans Parish by enabling local churches to educate congregations on health issues including hypertension, stroke, nutrition, fitness, diabetes, tobacco, and cancer prevention. Churches provide on-site screening and educational seminars for their congregations and communities using health modules that have been developed by the Healthy Community Partnerships, including the American Heart Association, Food for Families Commodities Nutrition Program, the Stanley S. Scott Cancer Center, and the American Cancer Society. In addition to educational materials and workshops on how to conduct the screenings and seminars, mimi-grant funds are available to participating churches. Grants ranging from $500 to $1000 are used to purchase items needed for seminars, such as VCR's, videos, blood pressure cuffs, and educational materials.

Objectives of the activity:

The goal of the Church-Based Program is to support the efforts of church based programs that are willing to take a leadership role to improve the health and well-being of their communities by conducting health seminars. Specific objectives are: 1. To enroll five churches the first year and 10 churches per year in subsequent years. Churches should be from each of the six council districts throughout the city. 2. To have participating churches conduct at least one community-wide seminar per month utilizing the health modules provided. 3. To provide modules addressing hypertension, diabetes, heart disease, stroke, and cancer and the corresponding preventative lifestyle changes. 4. To provide for other health modules when a church identifies a health problem not addressed by the developed modules. 5. To teach churches how to access other community health resources.

Barriers encountered in implementation:	Strategies to overcome barriers:
Our goal was to involve churches throughtout the city, but there was an overwhelming response from churches in one district.	Churches from the under-represented areas of the city were asked to recruit neighboring churches to apply, which yielded a good response. All six districts now have several participating churches.

Role of health department in implementation, planning, and evaluation:

Accomplishments:

The program is now entering its third year. Major accomplishments include: 1. Collaborations with other health agencies have expanded. 2. Modules have been developed for all of the chronic diseases targeted. 3. Grants have been awarded to 23 churches. 4. 4,345 people have participated in seminars and screenings in the past year alone. Numbers were not tallied for the first year of the program.

Lessons Learned:

Churches are an excellent vehicle for teaching health prevention. Congregation members care about each other and see each other regularly, reinforcing each others' attempts to make lifestyle changes and keep medical and screening appointments, etc. This takes health education out of the clinic setting and into the family and the community setting, where people are actually making and living their healthy lifestyle choices.

Research and Development Unit

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Population surveys (BRFS, PRAMS, PedNSS, YRBS) Hotlines, print materials, media campaigns Culturally appropriate health education Prepare, publish & distribute reports Public advocacy for legislation & resources Special studies Consistent, coordinated policies across programs MCH input in legislative base for health plans & standards Provide infrastructure/capacity for MCH functions Referral systems, resource directories, advertising , enrollment assistance Managed Care model contracts & access issues Identify alternative resources to expand system capacity	Increasing access to Medicaid Staff training Strategic planning Reshaping urban MCH Managed care initiatives Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, Other: The R&D Unit is a unit within the Bureau of Family and Community Health Services whose budget for FY1998 was $77,962,146

Budget: Not specified

Description:

The mission of the Research and Development Unit (R&D) is to assess the child health status and service needs of New York City's children and to implement coordinated improvements in access to health insurance and service delivery with public and voluntary sectors. The R&D Unit also conducts population-based research and develops programs to benefit and better the health of children, adolescents, women, and families. Specific activities the R&D Unit which are currently underway include: 1. Consulting on the creation of a system which ensures access to health services for children and recommending methods for implementing the New York State's initiatives on children's health insurance and Medicaid managed care under the section 1115 waiver. This involves working in collaboration with the State Department of Health, the Mayor's Office for Health Insurance Access, the Department Division of Health Care Access and the Children's Defense Fund; 2. Developing a plan of action to reduce infant mortality rates in specific communities in New York City; 3. Using ethnographic research methods, design and field test culturally and linguistically appropriate reproductive health education materials for women from diverse ethnic backgrounds; 4. Developing tools to assess public health nurses' knowledge of perinatal HIV transmission and training needs, formulating training opportunities for these nurses and evlauating outcomes.

Objectives of the activity:

Conduct and provide leadership in population-based and descriptive epidemiologic research. Coordinate the presentation of existing data on maternal and child health to make more useful for program development, grant proposals, policymaking in particular and for the broader children's health community in general. Serve as a body to make recommendations in issues related to access to health insurance and quality health care services for the maternal child health population.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barriers have been administrative related in the form of staff shortages; staff overload; and bureaucratic interruptions which have slowed down progress on projects.	To accomplish tasks, collaboration between department of health programs, other municipal agencies and the private sector was necessary.

Role of health department in implementation, planning, and evaluation:

The R&D Unit, originally named the Office of Child Health Planning in 1989, was established as a result of recommendations from the Mayor's Commission on the Future of Child Health in New York City. Since then, the Department of Health has supported its efforts by providing leadership and financial support.

Accomplishments:

Conducted a population-based study on the distribution of childhood asthma in New York City neighborhoods, using hospital-based data and ambulatory data from the Child Health Clinics and hospital-based clinics. Presentation of results was presented at the American Public Health Association Conference, 1997; the Ambulatory Pediatric Association Conference, 1998; and the New York City Academy of Medicine, Center for Urban Epidemiologic Studies, Asthma Conference, 1998. Evaluated the Every Child by the Year 2000 Program which assisted parents with applying and enrolling their children into the State's child health insurance plan, Child Health Plus and Medicaid. Presented results at Ameican Public Health Association Conference, 2000. Participated on the Department's Infant Mortality Task Force and co-conducted a comprehensive data analysis of vital statistics data to provide quantitative background on possible communities to target for intervention. Collaborated with the Office of Public Affairs, Cross-Cultural Communication (CCC); 19 women's health fact cards on reproductive health were translated into a bilingual format for the Chinese community addressing topics such as menopause, pregnancy, pelvic exams, pap smear exams, etc. To ensure that the fact cards communicated health information in a linguistically and culturally appropriate manner, the R&D Unit and CCC field tested them among Chinese women before distribution. Presented strategy at American Public Health Association Conference, 2000. Co-wrote the New York City PRAMS Grant which was awarded in 1999. Participated in the City**MatCH** Data Use Institute, Class of 1999-2000.

Lessons Learned:

Collaborations are extremely useful when resources such as funding and staff are limited. The key is to keep the project's momentum going until completion; keep lines of communication open and fluid with collaborators; and institute time lines to ensure adequate planning and development.

Safe Schools/Healthy Students Initiative/CAAN/Family Preservation

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Has this activity been formally evaluated?
Not Yet

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Development of models Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify & report access barriers	Family Violence Schools & health connections Other outreach activities Increasing social support Case coordination Reshaping urban MCH Child Neglect/Abuse Prevention Link Families to community resources

Funding Sources:
City/County/Local government funds, General state funds, Other Federal funds

Budget: $200,000.00

Description:

The Safe Schools/Healthy Students Initiatives Program currently serves 16 schools in the City of Norfolk, Virginia. The target population is those children with neglect issues, as identified by school personnel; which are not within the legal definition for neglect for intervention by Child Protective Services. Four full-time public health nurse case managers provide case management services to these families and make appropriate referrals to community resources.

Objectives of the activity:

1. To develop a plan of care with the family which will address their complex needs and link them with appropriate resources in the community including medical, dental, nutritional, housing, educational, employment, counseling, and mental health services. 2. To prevent child abuse and neglect.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Parents who have a very poor self-image. 2. Lack of support from partner, relatives or friends. 3. Financial difficulties. 4. Limited parenting skills. 5. Lack of knowledge regarding community resources. 6. Substance abuse.	1. Encouraging parents to seek support from other sources such as parent support groups/teen support groups. 2. Encouraging parents to continue and/or complete their education. 3. Linking parents with the appropriate resources in order to assist with financial difficulties, i.e., social services and employment programs. 4. Referring clients to parenting classes. 5. Educating clients regarding community resources available and how to access those resources. 6. Referring clients to substance abuse programs/counseling.

Role of health department in implementation, planning, and evaluation:

This project will serve 16 schools in the Norfolk School district. The Norfolk Health Department, in collaboration with other community agencies, proposes a community-wide approach to create a safe school environment, free of substance abuse and violence. This will be accomplished through home visits by public health nurses to assess medical, dental, nutritional, mental health as well as other needs to families with young children at risk for neglect. Data will be gathered to assess the progress each family achieves in their level of functioning. The data gathered will be used for improvement throughout implementation.

Accomplishments:

The formal evaluation of the data will be done as implementation progresses.

Lessons Learned:

Immunet Nebraska

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Implement public MCH Program client data systems	Immunizations Communicable diseases Building MCH data capacity Immunization tracking/recall

Funding Sources:
Other Federal funds

Budget: $165,000.00

Description:

Establishment of a statewide immunization registry.

Objectives of the activity:

The overall goal of the project is the prevention of vaccine preventable diseases among preschool children. The objectives of the project: 1. Enhance the ability of the community to monitor and track the immunizations of preschool children to increase age-appropriate immunization levels. 2. Address incomplete records due to fragmentation of health care delivery systems in the community. 3. Assist providers in assessing immunization needs for individual children within the framework of an increasingly complex immunization schedule.

Barriers encountered in implementation:	Strategies to overcome barriers:
The system has not been adequately funded to meet program needs, particularly in the areas of ongoing maintenance and further development. As was the case with many other states, Nebraska's immunization registry was greatly impacted by the bankruptcy of the immunization software vendor, HumanSoft. In addition, feedback from private sector pilot sites indicates that changes will need to be made for the system to be widely implemented in the private sector.	The Douglas County Health Department garnered support from the State of Nebraska Information System and Technology Department in the areas of programming, ORACLE support, and network administration. Programmers have made adjustments to the program code in order to fix several bugs and make the system Y2K compliant. A review and evaluation of the entire system will be necessary to effectively plan for the future and ensure that the resources necessary to adequately staff and possibly replace the system are available.

Role of health department in implementation, planning, and evaluation:

The system first implemented in the Douglas County public immunization clinics. At the urging of the immunization Task Force-Metro Omaha, the system was expanded to include neighboring counties, with future plans to implement in private sites. In 1996, Nebraska Health and Human Services contracted with the Douglas County Health Department to make the system available statewide in the public immunization clinics. To date, the system is operational in all Nebraska public immunization clinics, with one exception. The cooperative venture between the Douglas County Health Department and the State of Nebraska has benefited all.

Accomplishments:

The registry collects and manages immunization data for all but one public site in the State of Nebraska. There are currently 48 public clinics participating with 1.4 million immunizations documented for 140,000 children. Since implementation of the system, immunization levels in the public sector have increased due to enhanced tracking, recall, and record keeping. According to the latest National Immunization Survey (NIS) data, public sector immunization levels in Nebraska exceed those in the private sector by approximately 10%.

Lessons Learned:

Immunization registry systems must be continuously evaluated to remain current with the rapidly changing information technology field. When planning for implementation or maintenance of a registry, resources need to be allocated to accommodate the upgrading and possible replacement of the software on a routine basis to ensure that the system does not become outdated.

Integrated Message for HIV/STD Teen Pregnancy Prevention

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Development of models Newsletters, convening focus groups, advisory committees, networks Staff Training Provide outreach services	Teen pregnancy Communicable diseases Other outreach activities Staff training Building coalitions & partnerships

Funding Sources:

Budget: $250,000 per year for three years

Description:

The proposed project focuses its efforts on minority adolescents (minority defined as Black and Hispanic youth) and sexual minority youth 10-19 years of age who live in the areas with the highest reported STD cases and teen births in the county. Within this racial/ethnic age group, the proposed project will target sexually active youth, youths with STDs, youth who are injection drug users (IDUs), male youth who have sex with males (MSMs) and youth who are bartering sex for survival and/or other commodities.

Objectives of the activity:

Goal 1: To develop an implementation and evaluation plan to build the necessary community based infrastructure to improve the access of minority adolescents and sexual minority youth between 10 and 19 years of age to preventive health care services. 1. Develop a community-based coalition made up of youth service providers, outreach workers, community residents, community leaders (including political leaders), teachers, parents, targeted youth, etc. to draft a two-year work plan (including the development of a vision/mission statement) for the development of age- and culturally-appropriate messages and interventions to target minority adolescents and sexual minority youth between 10-19 years of age. 2. Develop and implement a needs assessment component to gather local data regarding the targeted group. The needs assessment will also incorporate data gathered through the Youth Risk Behavior Survey (YRBS) currently planned and implemented by Orange County Public Schools in the 1999-2000 school year. In addition to the YRBS, the needs assessment will include other data gathering mechanisms such as focus groups with Black and Hispanic youth (males, females, youth who engage in sexual risk behavior due to sexual orientation—i.e., MSM and females with MSM partners or with unknown sexual orientation--transgendered youth, male substance users and female substance users) and street youth. Surveys will also be conducted with organizations that provide preventive services to youth to assess community capacity and determine gaps to serve the above-mentioned groups. The protocols and instruments developed will be forwarded to the state office of the Florida Department of Health's Review Council for Human Subjects for IRB review and approval prior to implementation. 3. Establish contacts and developing relationships with existing youth programs (e.g., organized after school activity clubs, etc) in the area (including those that target street youth) to develop collaborative agreement to provide age and group appropriate messages and interventions. 4. Identify youth clubs (e.g., dance clubs, rave clubs, malls, tatoo parlors, piercing

halls, and other places where youth gather socially) and establish collaborative agreement with administrators and staff to identify the best channels to distribute preventive messages and implement interventions.

Goal 2: To develop community, culturally and age-prevention messages and interventions for minority adolescents and sexual minority youth between 10-19 years of age. 1. Identify nationally recognized messages and intervention programs (especially those that place emphasis on the peer outreach model) that focus on the prevention of HIV, STD and pregnancy among minority adolescents as sexual minority youth. The emphasis is to look at models that have shown effectiveness with the targeted groups. The interventions will be modified based on input from local youth. 2. Developing comprehensive and integrative (i.e., including HIV, STD and pregnancy prevention) sensitivity training (through workshops and/or presentations) for local health providers, outreach workers, community residents, community leaders (including political leaders), teachers, parents, etc. regarding the health needs of minority adolescents and sexual minority youth (focusing on the link between risk behaviors and HIV, STDs and pregnancies).

Goal 3. To share information regarding the process and instruments developed (i.e., evaluation instruments, protocols, training curricula, etc.) with other communities seeking to replicate the approaches to the integration of HIV, STD and adolescent pregnancy prevention. 1. Share information with community agencies, in CDC sponsored workshops, Orange County Health Department's (OCHD) internet and intranet links, TAPP and OCHD newsletters, at the American Public Health Association national conference, Society for Adolescent Medicine national conference, etc.

Barriers encountered in implementation:	Strategies to overcome barriers:
Gaining and maintaining the interest of community residents and providers around the issue of STD/pregnancy prevention. Finding common ground to ensure everyone's voice is heard--especially youth. Also the "morality" issue among the conservative Orlando community becomes a barrier to understanding behavior as a key component in prevention.	Working from a community perspective to develop communication channels and relationships. Incorporating the views and talents of the youth in the community.

Role of health department in implementation, planning, and evaluation:

The Orange County Health Department has played a key role in the process by supporting and developing an adolescent health unit. While the model is still under development, the health department has provided credibility for the issues currently being addressed; teen pregnancy prevention and the prevention of HIV and other STDs through integrated messages. In addition, the health department's research and evaluation unit will provide evaluation support to the efforts.

Accomplishments:

To date, the integrated messages efforts have appointed a working task force which provides guidance and work towards the accomplishment of tasks. Contacts have been made with various local youth-focused organizations. Partnerships have been established with at least 15 youth groups who have agreed to actively engage in the message design process.

Lessons Learned:

Among the lessons that we have learned from this effort is how difficult it is to get the voices of the youth heard when adults' opinions regarding certain issues are so strong. The issue of "morality" among the mostly conservative Orlando community has also presented a unique challenge when talking about behavior modification as a key component in prevention strategies.

KidCare Plays in Peoria

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Prepare, publish & distribute reports Public advocacy for legislation & resources Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Provide infrastructure/capacity for MCH functions Staff Training Support of health plans/provider networks Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity Identify & report access barriers	Dental programs Schools & health connections Other outreach activities Increasing access to Medicaid Staff training Building coalitions & partnerships

Funding Sources:
General state funds, Other Federal funds

Budget: $50,000.00

Description:

The Peoria City/County Health Department developed a community-wide program to assist families to successfully obtain health insurance coverage under Illinois' SCHIP called KidCare. Five strategies were identified and implemented. 1. Strategy: Assist families with the application process. Activities: Applied with the Illinois Department of Public Aid as an Application Agent, trained staff members to schedule appointments with families to complete the application, provided follow-up to compile needed documentation, mailed in completed applications, and tracked the acceptance of applications. 2. Strategy: Act as a resource to the community. Activities: Provided presentations to groups, clubs, churches, social service agencies, community organizations, business worksites, schools, healthcare providers, and governmental agencies; assigned a Health Department telephone line to provide KidCare information; supplied program fliers and posters to community agencies, grocery stores, gas stations, libraries, businesses, and discount department stores. 3. Strategy: Promote the program as a shared responsibility with community agencies and business. Activities: Trained other agencies to assist families with a mail-in application; encouraged agencies to make referrals to the health department; gained participation from organizations, businesses, and over 50 healthcare providers to actively promote the program through payroll fliers, posters, worksite presentations, and fliers for clients and employees. 4. Strategy: Work in partnership with the community to reach families where they work and play. Activities: Partnered with healthcare providers to provide basic application information on patients with the Health Department gathering documentation and mailing in the applications; partnered with social service agencies to make direct referrals of clients for the applications process with the Health Department; partnered with local interpreters to assist the Health Department with Spanish-speaking applicants and referral applications; worked with the local medical field representative from the Illinois Department of Public Aid to provide joint presentations; worked with the local Illinois Department of Public Aid to provide joint presentations; worked with the local Illinois Department of

Human Services to resolve local issues; and worked with a coalition for KidCare. Collaborated with 11 Neighborhood Associations to distribute over 4000 "goody bags" with KidCare information to those neighborhood residents. Convened with partners through Project Success, Peoria School District 150, OSF Saint Francis Medical Center, University of Illinois College of Medicine to promote a major school project; six school-based health centers participated along with 33 community volunteers from the convening committee including Peoria Promise Project, Children's Home, Heart of Illinois United Way, Division of Specialized Care, Proctor Hospital, and Methodist Medical Center. 5. Strategy: Advocate for families. Activities: Actively challenged the Illinois Department of Public Aid, the Illinois Department of Human Services, Illinois Maternal and Child Health Organization, the Lieutenant Governor, and local government officials to resolve enrollment problems within the KidCare program.

Objectives of the activity:

The overarching goal is to increase access to healthcare services for all children in Peoria County by: 1. Eliminating financial barriers to health care insurance coverage. 2. Engaging health care providers in assisting their families to obtain health insurance coverage. 3. Partnering with the community to develop a shared responsibility model to assist families to obtain Kidcare for their children.

Barriers encountered in implementation:	Strategies to overcome barriers:
Slow response by state agencies to establish sufficient infrastructure to support the outreach and enrollment activities at the community level.	1. Advocacy with local, regional, and state partners to respond to our needs and recognize our successful strategies. 2. Never accepting "no"--always suggesting an alternative. 3. Internal collaboration and staff training across divisions. 4. Develop a tracking system for enrollment status.

Role of health department in implementation, planning, and evaluation:

The Peoria City/County Health Department took the leadership role to plan, implement, and evaluate the KidCare enrollment process. Early consensus among Peoria City/County Health Department's Maternal Child Health Community Advisory Board identified the Health Department as the best agency to lead the community collaboration.

Accomplishments:

1. By first Quarter 2000: Peoria County has processed and approved more applications than any other of the 102 counties in Illinois. 1538 applications approved in Peoria County out of the state total of 86,000. 2. The Peoria Health Department acceptance rates for applications is 85% compared to the state-wide average of 78%. 3. Trained over 50 agencies, schools, social service agencies, etc. to assist families with mail-in applications. 4. Recognized resource in community for KidCare and access to healthcare services information.

Lessons Learned:

1. Building a strong community support allowed the Health Department to function in a well-coordinated collaborative environment that provided key to our success. 2. Internal collaboration to redirect resources (human and fiscal) between four divisions in the Health Department--Public Health Nursing, Dental, Fiscal-Administration, and Health Promotion and Education to broaden the internal collaboration so more Health Department staff were knowledgable regarding enrollment requirements and act as a resource.

Love Your Body!

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Provide outreach services	Substance abuse prevention School-linked/based services Teen pregnancy Teen parenting Schools & health connections Other outreach activities Building coalitions & partnerships

Funding Sources:
City/County/Local government funds

Budget: $1,000 for materials, plus staff time

Description:

"Love Your Body!" is an interactive workshop presentation that encourages teen girls to develop a healthy body image, and to recognize the health risks promoted by advertising and media (i.e., smoking and alcohol consumption, unrealistic body weight and unhealthy diets). Educators from the Philadelphia Department of Public Health present workshops in teams of two to middle- and high-school classes throughout Philadelphia during regular school hours. Teens review and discuss advertising images in popular magazines, analyze the "hidden" messages in fashion layouts, challenge the stereotypes that often define women's representation, and suggest ways to counter the influence of the media on health behaviors. The workshops draw a clear connection between advertising and such pervasive health issues as anorexia/bulimia. They encourage teens to develop self-esteem and question media myths.

Objectives of the activity:

"Love Your Body!" seeks to reduce such unhealthy behaviors as: smoking, crash dieting, fasting, abuse of weight-loss supplements and over-exercising. Workshop discussions are designed to encourage critical and independent thinking among teen girls about the influence of advertising on their behaviors.

Barriers encountered in implementation:	Strategies to overcome barriers:
Workshops are limited to about 50 minutes (a single period), which provides adequate time to fully discuss a range of complex issues. Though response to the workshops has been overwhelmingly positive from students and teachers alike, the time restrictions inevitably limit the workshops' effectiveness. The initiative also has been hindered by occasionally disorganization on the part of the school/teacher, and by rowdy and disrespectful behavior on the part of the students.	Closer collaboration with school principals and teachers has helped to overcome the barriers above. Negotiations on time limits are continuing on a case-by-case basis.

Role of health department in implementation, planning, and evaluation:

The Philadelphia Department of Public Health collaborated with the local chapter of the National Organization for Women (NOW) in the Fall 1999 to announce "Love Your Body!" Day. Since then, the department has assumed full responsibility for arranging presentations at area schools, developing curricula for various ages and class sizes, evaluating and ordering print and video materials, and responding to requests for information from schools, community groups and the media.

Accomplishments:

More than 525 students in Philadelphia schools have participated in "Love Your Body!" workshops since the Fall of 1999. The initiative has received coverage in the *Philadelphia Inquirer*, the area's major daily newspaper. During the school year, workshops are conducted an average of once a month by a core team of "Love Your Body!" educators (including, on occasion, a male presenter for co-ed classes).

Lessons Learned:

A "one-hit" workshop is inadequate to fully address the complex issues of body image, media and advertising, and adolescence. Most girls have expressed desire to continue the discussion raised by "Love Your Body!" An expanded program (at least three sessions per workshop) would help to enhance its effectiveness and impact.

South Phoenix Healthy Start

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Prepare, publish & distribute reports Newsletters, convening focus groups, advisory committees, networks Promotes compatibile, integrated service system initiatives Staff Training Support of health plans/provider networks Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them	Preconception promotion Prenatal care Expanding maternity services Low birthweight/infant mortality Overcoming cultural barriers Reducing transportation barriers Other outreach activities Case coordination Increasing access to Medicaid Staff training Strategic planning Building coalitions & partnerships

Funding Sources:
MCH block grant funds

Budget: $300,000.00

Description:

The South Phoenix Healthy Start Project is a partnership between Baby Arizona and the Maricopa County Department of Public Health. This project has been in action for several years with a very successful South Phoenix Healthy Start Coalition. One of the goals of this year was to design and implement a coordinated/collaborated plan with agencies that provide outreach to pregnant women and teens in South Phoenix. Three such action plans were developed.

Objectives of the activity:

Action plans focused on three specific issues: develop a universal referral process in South Phoenix, develop more culturally sensitive services, and coordinate/notify each South Phoenix agency conducting pregnancy outreach of community events.

Barriers encountered in implementation:	Strategies to overcome barriers:
Maintaining a current list of Baby Arizona medical providers, a list of medical providers who accept Federal Emergency Service clients, and a list of medical providers who offer package prenatal/delivery plans for clients without any insurance is difficult.	A resource directory is out of date when it is published. The Coalition meetings are very well attended, however, and program/provider updates are disseminated. The Resource Directory is being developed for the Maryvale area of South Phoenix using a different process directory to collect data than was used for the South Phoenix.

Role of health department in implementation, planning, and evaluation:

The Maricopa County Department of Public Health was a principal partner in the organizing of the South Phoenix Healthy Start Coalition. This coalition has been very effective in improving access to prenatal care for women in South Phoenix. The action plans and other activities are coalition accomplishments. The Maricopa County Department of Public Health continues to provide technical assistance, administrative and other related support, and case management for high risk women. The Department completes a yearly MCH Needs Assessment with a focus on South Phoenix.

Accomplishments:

1. At least 20 providers and outreach workers became more knowledgeable of South Phoenix resources. 2. Barriers to service delivery in South Phoenix were identified. 3. Three action plans were developed and are being implemented.

Lessons Learned:

Finding advocates within the South Phoenix community and empowering them as leaders for the direction and maintenance of the coalition has resulted in a more sustainable organization.

Primary Care Partnerships

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Public advocacy for legislation & resources Development of models Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity	Expanded child health services Overcoming cultural barriers Reducing transportation barriers Expanding private sector links One-stop shopping locations Increasing access to Medicaid Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Third party reimbursement (Medicaid, insurance)

Budget: $850,000.00

Description:

Prior to 1993, the Department sponsored a large network of well-baby clinics. With the implementation of Medicaid managed care, the well-baby clinics were transitioned to primary care partnerships. The result is two partnership models. At three sites, the Department provides the facility and the nursing and support staff, furnishings and most supplies. Our partners provide the medical staff (nurse practitioners and physicians), after-hours coverage and billing services. At three other sites, the Department provides nursing home visits for prenatal and high-risk pediatric patients, coordinated with primary care services. Our partners include major hospitals, a federally-qualified community health center and a multipurpose community center. The partnerships are located in communities that had both a large well-baby clinic and a primary care provider.

Objectives of the activity:

The goal is to provide affordable care for the uninsured and underinsured in Allegheny County through comprehensive primary care centers that integrate the medical and public health models. Social services and home visiting services are available at all these primary care centers. Staff also work in a variety of ways to help clients stay well. They provide patient education on site and participate in many health education activities in the community.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barriers were effecting the necessary changes within our Department. Interpreting for all staff the rationale for transpositioning the well-baby clinics, supporting staff in their new roles and learning to work in partnership all required much work. The most difficult issues in working with our partners have included the development of an affordable fee structure and having medical staff at each center at least part of each day who understand and are committed to the center and the goals.	Leaders must clearly understand the goals and communicate them clearly. Advance planning with our partners was minimal. The focus was on getting services established and then working to resolve problems and complete necessary planning. In fact, problem-solving and planning for enhanced services are ongoing.

Role of health department in implementation, planning, and evaluation:

The Department took the lead in contacting potential partners. During implementation, the relationship has been collaborative and the lead has been shared. The Department is currently working to evaluate how well the partnerships are serving the uninsured/underinsured.

Accomplishments:

There are now more primary care providers available to the uninsured/underinsured. During 1999 there were over 7,500 visits to the three centers we staff. Infants, children and teens who are initially uninsured got health coverage through staff assistance with enrollment in Medicaid or the Children's Health Insurance Program (CHIP). Fees that were initially unaffordable have been reduced significantly. The Centers are increasingly seen as vital components of the communities they serve.

Lessons Learned:

In many ways, the Primary Care Partnerships are "pearls." They did, indeed, start as irritants to many, but they have become beautiful! There were many hard-learned lessons along the way. Working closely in partnership with another entity was new for our partners and for us. The need for flexibility, diplomacy and patience was and is great!

Smoke Free Families Research Proposal

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Special studies Identify high-risk/hard-to-reach populations & methods to serve them Profiles of provider attitudes, knowledge & practice Identify & report access barriers	Low birthweight/infant mortality Substance abuse prevention Expanding private sector links Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, MCH block grant funds

Budget: $5,000.00

Description:

As part of our DUI Project on building a Perinatal Smoking Surveillance Network, our 15-member D.U.I. Team elected to proceed ahead with submitting an application to the R.W.J. Smoke Free Families Initiative to conduct an observational research study on postpartum smoking relapse. The search for a principal investigator (P.I.) resulted in finding a researcher from one of the local universities who was new to the area and who has since become an invaluable member of our DUI Team. The Public Health Division also partnered with our local medical center in their intervention study proposal to R.W.J. that complimented our study.

Objectives of the activity:

Develop research study that would augment and enhance the work of our Perinatal Smoking Surveillance Network. Secure funding from R.W.J. to conduct study. Use study findings to inform and guide Network that in turn informs and guides health care providers working with women who smoke perinatally.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Encounter some unexpected academic rivalry and politics while in search for a Principal Investigator for our study. 2. Many cooks made for a muddy and over-spiced stew when it came to proposal writing by committee. Prior to finding our P.I., we attempted to draft the Letter of Intent through group assignment, which proved to be both time-consuming and unproductive. 3. The vagaries of communication by E-mail when soliciting input from various members from various locations was both a blessing and a curse.	In the end, our Principal Investigator took the lead on crafting and designing our study and drafting the proposal. This streamlined the process considerably and also proved to be a catalyst for solidifying our DUI Project.

Role of health department in implementation, planning, and evaluation:

The health department is the lead agency in our 15-member D.U.I. Team and was the applicant organization for the R.W.J. research proposal.

Accomplishments:

Although the R.W.J. proposal was ultimately not selected for funding, the often arduous process of putting it together forced us to focus our efforts and further concretize our D.U.I. Project. It also resulted in the addition of the proposal's Principal Investigator to our D.U.I. Team, whom we otherwise would not have known. She has been and continues to be a committed and irreplaceable asset for our team.

Lessons Learned:

The rewards and benefits of putting a project together may not always be what you anticipate or expect. The long-term benefit that has resulted from forging this ongoing partnership without university research has proven more valuable than the funding that we might have received from R.W.J. We also have benefited from our partnership with the local medical center, whose intervention study was also rejected for funding.

Universal Screening of Clients for Family Violence

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives

Funding Sources:
City/County/Local government funds

Budget: Not Specified

Description:

During the fall of 2000, Multnomah County Health Department (MCHD) began to phase in a program of universal screening of all adults and adolescent clients for family violence. In this context, family violence is defined broadly to include intimate partner violence, child abuse and other forms of violence within the family. The program is unique in screening for any involvement in family violence, i.e., either victimization or perpetration of family violence. The decision to undertake this wide-scale screening program arose from the Department's 1998 strategic plan. The plan identified family violence as a critical public health need, and called for universal screening as a reasonable personal health services response. The Department's Violence Prevention Coordinator (in the Planning and Development Unit) was given responsibility for developing and implementing the program. She convened a working group representing all the major service delivery arms of the Department—primary care clinics, school-based health centers, field service/public health nursing, and corrections (jail) health. Over approximately one year, this work group developed detailed policies, procedures and protocols to implement the screening program. Beginning in the summer of 2000, there was extensive staff training for all health department staff in one of the health department's six service areas. Training was tailored to specific staff roles. All staff received a minimum of four hours of introductory training on family violence. Selected staff received more intensive training that was specific to role expectations. Direct service providers such as physicians, mid-level clinicians, and community health nurses received the highest intensity training. One feature of the program was development of family violence crisis teams at each service delivery site. These teams were charged with serving as consultants and case managers for client families with urgent and severe violence situation. The program was implemented, and will be monitored and informally evaluated in the pilot service area. It will then be refined and disseminated in a stepwise fashion to the County's other service areas and to corrections health.

Objectives of the activity:

Training has been completed for staff in the pilot service area, and universal screening has begun. At this time, all the clients coming in for routine services are receiving screening.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barriers to implementation of screening have been: 1. Scarcity of community-based resources to provide family violence specific-services to clients with identified needs; and 2. Concerns on the part of community partner violence advocates that screening in the absence of fully developed and funded community service capacity could be harmful. This concern has been posed as the question: "How can you guarantee that no one will be harmed?"	The department has dealt with these barriers by working in partnership with community-based service agencies that provide family violence-specific services. The partnership has created reasonable and effective referral pathways. The same agencies have also been involved with the Health Department as staff trainers and consultants.

Role of health department in implementation, planning, and evaluation:

This is primarily a project of Multnomah County Health Department. As described above, we have involved community agencies in development and implementation of the program.

Accomplishments:

1. All staff within the initial implementation area have been trained to provide them with a basic background on family violence. 2. Screening of all adults and adolescent clients (including men) is underway. 3. The implementation process has also raised awareness of family violence among staff, and has prepared staff of all levels to serve as community referral resource people.

Lessons Learned:

Than there has been a very high degree of enthusiasm and support by health department staff at all levels. Provider and support staff have long recognized that family violence is a core issue for many of the families that we serve. We learned that it is possible to channel this staff concern and energy into an effective systematic intervention to deal with the complex issue of family violence.

Providence Childhood Lead Task Force

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Environmental Assessments Develop & promote MCH agenda & Year 2000 National Objectives Increase availability of lead-safe housing	Early intervention/ZERO TO THREE Lead poisoning School-linked/based services Overcoming cultural barriers Schools & health connections One-stop shopping locations Other outreach activities Case coordination Building coalitions & partnerships Building MCH data capacity

Funding Sources:
Other Federal funds, Other: In kind State MCH Staff Support

Budget: $25,000.00

Description:

Coalition of health, housing, social service agencies organized to plan for addressing large number of houses with lead hazards and an epidemic of childhood lead poisoning. One out of three preschool children with EBL's (elevated blood levels) (Pb ≥ 10 mgm %)

Objectives of the activity:

Identify strategies to increase resources for lead hazard abatement, enforcement of housing quality standards, reduction in numbers of newly poisoned children, improvement in case management.

Barriers encountered in implementation:	Strategies to overcome barriers:
Limited family resources, no state housing subsidies, limited Federal assistance; high rate of immigration, non-English speaking families.	Grant support obtained from HUD around 6-4 million new dollars for education of families, abatement resources.

Role of health department in implementation, planning, and evaluation:

To provide technical assistance, data support, and epidemiological support.

Accomplishments:

Establishment and implementation of a HUD funded lead abatement plan for Providence. This includes environmental case management, housing relocation, and coordination of medical follow-up.

Lessons Learned:

1. There are huge gaps in policy standards and enforcement for safe affordable housing. 2. In urban communities it is critical that health departments form collaborative relationships with housing regulators and providers to address access to safe affordable housing.

Enhancing Developmental and Behavoral Pediatrics

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Development of models Support of health plans/provider networks Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity	Early intervention/ZERO TO THREE EPSDT/screenings Reshaping urban MCH Building coalitions & partnerships working with private pediatricians

Funding Sources:
Other: Wake County Smart Start

Budget: $144,081.00

Description:

Most pediatric practices, public and private, do not devote adequate time and resources to the developmental and behavioral components of well-child care. Reasons given for not providing this important component of pediatric care include: too little time during office visits, lack of knowledge about effective and reliable screening tools, and lack of skills in using tools if available. Borrowing from several creative models developed in Boston, Wake County Human Services has placed specially trained development specialists in three clinical settings to: perform developmental and behavioral screenings; identify at-risk children and families; counsel and advise parents; refer children to area resources; and, consult, advise, and provide training for clinical office staff.

Objectives of the activity:

1. Incorporate developmental surveillance as an integral part of the pediatric office visits. Identify these children who need referral for further and more specific developmental assessment and facilitate those referrals. 2. Increase the competence and confidence of private pediatric staff to incorporate age and problem appropriate developmental and behavioral screenings using validated and efficient screening tools into their practices. 3. Demonstrate a model for increasing community capacity to identify children and families at risk for developmental and behavioral problems, link to available resources and provide continued monitoring and support to the families.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Identifying fiscal resources to provide service and training to office staff. 2. Identifying effective training strategies in order to compliment and be most efficiently incorporated into the individual practices. 3. Continuing and expanding the model program.	1. Partnership with Wake County Smart Start to fund pilot program implementation and evaluation. 2. Outreach to the private pediatric community to gather support for program continuation and expansion. 3. Pilot training with pediatric staff and concurrently getting feedback of the most effective training modalities and components needing changes. 4. Providing information such as web links, literature, and organizations for the pediatric offices to continue to expand their knowledge base.

Role of health department in implementation, planning, and evaluation:

Wake County Human Services has an ongoing relationship with Wake County Smart Start, including extensive board and committee membership. The community needs assessment identified the need; agency staff inventoried and developed the model; applied for the pilot funding; hired staff; and implemented the program.

Accomplishments:

1. 350 children, ages 0-5, including 80 Latino children, are receiving developmental surveillance, anticipatory guidance and support through this project. 2. 19% (87) of the children screened were referred for further evaluation in the areas of speech/language, behavior, and social development. 3. With increasing interest and inquiries from the medical community, in the process of developing a training module for incorporating Developmental Specialist into medical practices.

Lessons Learned:

1. Clarification of describing program intent. 2. Reach out for support of private medical community. 3. Engage bilingual developmental specialists.

Head Lice Project

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems	Expanded child health services
Development of models	School-linked/based services
Develop & promote MCH agenda & YR2000 National Objectives	Schools & health connections
Identify high-risk/hard-to-reach populations & methods to serve them	Other outreach activities
Provide, arrange, administer direct services	Increasing social support
	Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Private source(s): Blue Cross/Blue Shield of Rochester; Rochester-Monroe County Youth Bureau; Daisy Marquis Jones Foudation; Center for Youth Services

Budget: $95,000.00

Description:

Monroe County Health Department teamed with the Department of Social Services and the Rochester City School District during the 1999-2000 school year to address the poor attendance with chronic head lice. A specially trained group of Home Health Aides from Interim Health Care was assigned to selected schools. School nurses from the Health Department, in conjunction with the RCSD Attendance Office, identified students at risk because of chronic head lice. Whenever the selected students were found to have head lice, the aides, with parents' permission, treated the head lice and/or combed out nits. This was done in school and the students returned to class the same day instead of going home. In addition, school nurses conducted home visits if parents were willing, to educate parents on how to treat head lice; to assist the need for support services; and to try to identify possible causes or sources for the lice infestation. Potential support services included assistance with housekeeping and funding for needed items, such as vacuum cleaners.

Objectives of the activity:

Short Term Objectives: Remove lice and/or nits from child and return to class the same day, reduce lice transmission, reduce frequency of reinfestation, reduce need for treatment and/or length of treatment, increase families' ability to deal with head lice, eliminate the source of the lice infestation for each family. Long-term Objectives: Reduce the number of days absent from school of children who are chronically infested with head lice, increase state aid by reducing the number of lost days, reduce the number of DSS families sanctioned (by a financial penalty) due to school nonattendance, improve identified students' academic performance.

Barriers encountered in implementation:	Strategies to overcome barriers:
Head lice was identified as a problem by multiple agencies and disciplines, but no one wanted to take ownership of the problem. There was a baseline level of frustration, anger, and misunderstanding over the issue among parents, teachers, and the community. Recruitment and training of aides; finding a place for them to work in crowded school buildings. Enlisting the cooperation of Health Office staff, who saw the problem as hopeless. Supervision and monitoring of the aides' activities became an additional responsibility of already very busy Health Office staff. Gaining/maintaining cooperation from families in following through on the activities they need to do at home to control the lice. Some families refused the home visit portion of the program, and without that the in-school portion was merely palliative.	An interagency partnership was formed and focused on desired outcomes instead of "whose problem is this?" Cooperation and enthusiasm was mustered by focusing on one specific achievable and measurable outcome—increasing the affected students' time in their classrooms—because everyone involved agreed that was desirable. Home Health Aides were recruited using financial incentives and by making them feel they were part of something special. Health Office staff (RNs, LPNs, and School Health Aides) received support from their supervisor and participated in meetings to discuss and evaluate the project. Nurses increased their efforts to visit these families, employing creativity in "getting in the door." Parents were invited to come into the school to learn as the aides were treating and combing out lice/nits.

Role of health department in implementation, planning, and evaluation:

The School Health Services program of the Monroe County Health Department, which provides health services to the Rochester City School District, has been involved in all stages of this project. The Coordinator and one nursing supervisor participated in the initial problem solving process, which evolved into a task force that has continued to meet to direct and evaluate the project. The nursing supervisor has provided clinical supervision, as well as ongoing coordination and evaluation of the project. The Health Department staff assigned to the selected schools participated in the day-to-day carrying out of the project activities, including identifying students, monitoring/supervising the Home Health Aides, coordinating with school staff, recordkeeping, and teaching/counseling (both in the school and in-home visits.)

Accomplishments:

For the 341 students who were identified as having chronic head lice infestations, 609 treatments and 1,166 comb-outs were done. That is 1,775 days those students stayed in school instead of being sent home. For 74 of those students, the chronicity of the infestation was impacted (i.e., they had long periods of time without any head lice). In addition to the 1,775 days the students stayed in school, the following school days (that the parents of these students would have kept them home to treat them) were saved. Preliminary reports indicate that attendance was improved for the period of time the project was in place. The cost savings to the district in terms of state aid will also be measured. Some families received support services and/or needed items to help them manage the problem at home (for example, six families received vacuum cleaners.) Of the seven schools participating (all seven were known to have an ongoing lice management problem) three achieved a level of control that eliminated lice as a major, everyday, time consuming issue. In addition, principals and teachers are reporting on individual students whose social and academic performance has improved significantly. For example, one principal tells a story of a student who was failing academically, and who did not communicate with his peers at all, who became the leader of his work group after his head lice was dealt with.

Lessons Learned:

While head lice are a "nuisance" problem, not a health hazard, there are significant academic, social and financial ramifications when children are chronically infested. Past experience has been that, with support, most families are able to eliminate the head lice. However, for various reasons, some families can't. We learned that instead of trying to change the unchangeable, it is possible to have a positive impact on the lives of the children affected. By teaming with several agencies that did not individually want to "own" the problem and focusing on mutually agreeable positive outcomes, it was possible to coordinate financial and human resources to achieve those outcomes.

Childhood Lead Poisoning Prevention Services Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Environmental Assessments Implement/support education services for special MCH problems Promotes compatibile, integrated service system initiatives Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Expanded child health services Lead poisoning Children with special needs One-stop shopping locations Other outreach activities

Funding Sources:
General state fund

Budget: $14,000.00

Description:

In order to improve early lead detection and intervention in children, the Winnebago County Health Department supports the CDC Childhood Lead Poisoning Prevention Services Program, which provides lead screening, education, home case management and home inspection services. During the past year, the Childhood Lead Poisoning Prevention Service Program was integrated into the WIC program, shifting the program from the Health Promotion Division within the department to the Health Support Services Division. This shift has allowed all of the lead services, lead screening through blood draws, education and case management, to be located in one division, thus increasing the likelihood that lead levels will be detected and that children will receive follow-up services needed. When children come in for WIC food coupons and for nutritional counseling, they receive a lead draw along with their required hemoglobin test, combining these services in one visit. Further, because the lead program is located in WIC where clients are talking with nutritionists, it allows staff the opportunity to assess potential lead risk and to provide education about the dangers of lead to all clients. With a caseload of more than 6,500 clients, housing the lead program in WIC has greatly increased outreach to children, increased the number of lead screens conducted, and increased informal assessment and education to parent's about lead. Prior to integration, no lead screens were conducted and counseling/education was provided only to children identified through the State Lead Screening database as having a lead problem and thus providing no opportunity for preventive education.

Objectives of the activity:

1. Initiate lead screens for children turning one year who are in the WIC program. 2. Increase lead screening for WIC children who attend clinic and are turning one year old from 0-50%. 3. Provide case management follow-up services for all children (100%) exposed to lead to include health and environmental assessment, nutritional counseling, intervention education and assistance with home inspection and clean up. 4. Provide preventive education and informal assessment to 100% of WIC children who receive nutrition education.

Barriers encountered in implementation:	Strategies to overcome barriers:
Most of the barriers in implementation were associated with the newness of the program. There was resistance to learning about and conducting a new program among direct service staff, especially among staff who would be conducting lead screening for one year olds. There was also resistance by parents to agree to the lead screen for their child. Learning about the reporting and surveillance system as well as funding requirements and procedures for reimbursement were also impediments in the initiation of the program. Because the program was new to this department, there was resistance to the change and assimilation of a new program.	Education and training have been provided to direct service staff who are performing the lead draws, emphasizing the importance of early detection. To better integrate WIC and lead services, lead draws may be taken at one year or 18 months, partnering the lead draw with the hemoglobin test. Combining two blood draws to one helps to address staff and parent resistance. Barriers have also been addressed by communicating the importance and the success of the program, helping to convey the impact of their efforts.

Role of health department in implementation, planning, and evaluation:

The planning, implementation and evaluation of this activity has been solely conducted by the Winnebago County Health Department through the utilization of the CDC Stellar software program, which compiles weekly data about children with at-risk blood levels. In implementing the program, the WIC department conducts lead screens on all children turning 1 year old, a nurse assigned to this program provides case management through home visits to children testing at 20 up/dl. WIC nutritionists and family case managers conduct an informal assessment and provide education to all parents. The WIC department and the Environmental Health Department collaborate to conduct inspections. Evaluation is done by the Programs Supervisor through tabulation of the number of monthly lead draws conducted for one year olds, and monitoring the distribution of education material and case management to assure that compliance rates are at 100%.

Accomplishments:

Accomplishments include extending lead screening and lead education to a much larger community audience through the targeting of the WIC population (caseload=6,500). Services are delivered to parents and children at the same time that they are receiving WIC services. During the last quarter, 50% of WIC children turning one received a lead screen, compared to 0% one year ago. All WIC and Family Case Management clients receive counseling and education about lead (combined caseload 9,584). A WIC lead specialist and Environmental health staff have collaborated efforts and expertise to conduct home visits, providing case management and education with home inspection and potential lead abatement.

Lessons Learned:

Because the number of clients receiving WIC services is so large, combining services to include lead education and screening is an effective strategy for increasing outreach and delivering education. This activity has increased the number of children receiving early detection and intervention. Integrating services within and without department can be very effective, as communication among staff is improved and service delivery is more efficient, streamlined and tailored to meet client needs. Because staff sometimes have difficulty with change, it is important when possible to seek their "buy in" when adding new programs. When staff are not in agreement about changes, hearing their concerns and ideas can help to increase their receptiveness to change.

Hispanic Prenatal Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Culturally appropriate health education Newsletters, convening focus groups, advisory committees, networks Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Prenatal care Home visiting Low birthweight/infant mortality Children with special needs Teen pregnancy

Funding Sources:
MCH block grant funds, Private source(s): North West Health Foundation

Budget: $200,000.00

Description:

Partnership with two community providers to provide prenatal care to undocumented Hispanic women, ineligible for insurance or the Oregon Health Plan. This partnership is a result of obtaining a special grant to provide prenatal care to 110 women per year on $50,000. After a positive pregnancy test is performed at the Health Department, a risk screening is conducted to find suitable prenatal care. High risk criteria established by the partnership is used in determining where to refer the client for care. Lower risk clients are referred to local nurse midwives or to a private low income clinic for their care and delivery. Higher risk clients are kept by the Health Department Nurse Practitioners under consult from Oregon Health Sciences University. The Health Department is a satellite clinic of OHSU hospital, and sends a perinatologist to the Health Department once monthly to monitor these high risk clients.

Objectives of the activity:

The primary purpose is to provide medical care providers for Hispanic undocumented prenatal clients. The goal to improve birth outcomes for Hispanic clients who receive prenatal care by the partners would be measured by 95% of babies being delivered healthy and of normal birth weight.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Finding partners willing to take a very modest fee to provide the prenatal care. 2. Finding partners bilingual, or with staff able to provide culturally appropriate care. 3. Funds for lab and ultrasounds.	1. Organizing community provider prenatal planning sessions to talk about, and share concerns among OB providers. 2. Providing data on changing demographics for community. Health Department aware of bilingual need and already recruiting bilingual staff. One other community medical provider has just hired four new bilingual MD's.

Role of health department in implementation, planning, and evaluation:

The health department has been and still remains an integral part of this project. The health department implemented the beginning planning sessions and negotiated with potential partners before actually writing the grant proposal. All clients are first assessed by the Health Department. The Health Department organizes monthly partner meeting, reviews data, compiles and writes the quarterly reports to the grantor, and facilitates the community meeting working for sustainability.

Accomplishments:

1. Have served over 75 Hispanic clients to date. 2. All deliveries have been normal birthweight.

Lessons Learned:

1. Bringing people together to talk about issues and concerns does take time to build trust. 2. Improved understanding by private providers is the role the Health Department plays in providing prenatal care. 3. Results of more community planning will be a "coalition of providers" whose sole concern is finding ways to continue providing prenatal care for Hispanic women.

Dental Clinic Collaboration

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Promotes compatibile, integrated service system initiatives Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Dental programs One-stop shopping locations Increasing access to Medicaid

Funding Sources:
City/County/Local government funds, General state funds, Private source(s): Donations from community, Other Federal funds, Third party reimbursement (Medicaid, insurance)

Budget: Not specified

Description:

In Utah, the continued need for dental care was documented in a survey conducted by the Utah State Health Department. In 1998, there were 1200 dentists in Utah, 750 of whom were Medicaid providers. Of these 750, only 88 of the dentists, when surveyed, stated that they would accept new Medicaid patients. Of those 88, many of these dentists indicated that they would accept new Medicaid clients on a limited basis only. In Utah, there were 211,000 eligible clients per year on the Medicaid program and only 48,000 of those clients received dental services. It was estimated that if access were improved, at least 50% of the eligibles would seek dental care. Many of the clients needing dental care are children in the Salt Lake area. To address this problem the Salt Lake Valley Health Department and the Utah State Health Department collaborated to open a pediatric dental clinic.

Objectives of the activity:

1. To improve the oral health status, address dental needs, and provide access for children with Medicaid or CHIP and the uninsured population who do not have a private dentist. 2. To develop a model of preventive dental care as an integral part of early childhood primary care. 3. To provide education regarding the importance of infant dental examinations and other interventions. 4. To reduce the incidence of dental caries in young children, particularly the incidence of "baby bottle" decay.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barriers to implementation were: 1. obtaining necessary equipment; 2. finding suitable space; 3. developing contractual agreement between parties; 4. finding and hiring bilingual staffing for the clinic; 5. remodeling of space; and 6. funding. One of the most suprising barriers was selling this bright idea to other county administrators. What seemed to apparent to those of us working closely with children needed to be justified with numbers and proven that investments in this dental clinic would ultimately save	The barriers were overcome by developing an effective working relationship between the state and local health departments. Statistics were obtained by the state health department. Local health department staff created and submitted proposals to justify the creation of this joint clinic venture, which is now widely supported in the community and within both departments. Clients without Medicaid or insurance are seen according to the Medicaid reimbursement rates and billed for services, are not denied services

money. There are many area residents who are without Medicaid or insurance coverage and who are in need of dental care.	for the inability to pay. The Salt Lake Valley Health Department and the State Dental Office collaborated with community partners to donate office and dental equipment. The State Dental Office dedicated money to buy necessary x-ray and dental equipment. Local construction contractors donated hours of construction work, materials, electrical and wiring materials, and plumbing work. A dental clinic space was made by coverting an unused area of the public health center into an office, storage/file area, and patient receiving area. The x-ray equipment used in this setting did not require lead lined walls. The State Dental Office hired the dental staff, which included a bilingual dentist, dentist assistant, and receptionist. Dental supplies were purchased by the Health Department for use with uninsured patients. Dental assistants from the Salt Lake Community College School of Hygiene provide donated preventive care to children. Patients are referred from the WIC and prenatal areas of the clinic. On-site Medicaid eligibility workers enroll clients on Medicaid and CHIP.

Role of health department in implementation, planning, and evaluation:

The local health department assisted in the planning of the clinic, defining the desired outcome, and implementing the clinic in the Health Department facility.

Accomplishments:

The clinic has been very successful and is very supported in the community. Other joint ventures are being discussed. Like most low-cost dental clinics, there are more people who need to be served than there are appointments available.

Lessons Learned:

Collaborations in providing dental care can be very successful. It is very important to include community partners. There are partners in the community who are willing to donate nontraditional items such as construction costs and materials. Likewise, it is important to recognize and thank them for their contributions publicly. We recognized those who donated items and time at an open-house, in the press, and in our Board of Health meeting. It is important to maintain continued and ongoing communication to keep the collaboration functioning effectively.

School Health Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education Prepare, publish & distribute reports Development of models Develop & promote MCH agenda & YR2000 National Objectives Newsletters, convening focus groups, advisory committees, networks Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff Training Support of continuing education Support of health plans/provider networks Provide outreach services Profiles of provider attitudes, knowledge & practice	School-linked/based services School-linked/based services Schools & health connections Staff training Reshaping urban MCH Building coalitions & partnerships

Funding Sources:

Budget: $47,000.00

Description:

In January of 2000, the San Antonio Metropolitan Health District appointed a public health nurse to function as a liaison between the department and the 16 school districts in Bexar County. The school liaison continues the relationships already established with the school nurses and enhances them further through assessment of district/school specific needs, development of action plans, and through consulting together on public health issues. Targeted areas include: communicable disease, public health information, health policy, statistical information and educational opportunities. The goal is to promote positive health outcomes among students and families, as well as the school community in general. As a result, the position has evolved into the "School Health Program." Educational programs have been made available, bringing together public health nurses and school nurses. Multiple informational handouts have been provided by SAMHD to parents by way of the schools. A web page was created as a resource for school nurses, www.SAMHD.org.

Objectives of the activity:

1. To provide a link between the San Antonio Metropolitan Health District and the school nurses in Bexar County. 2. To increase the delivery of public health information and education to the school districts. 3. To develop consistent and effective policies across the school districts as related to public health. 4. To gather and disperse applicable health statistics as related to specific school districts.

Barriers encountered in implementation:	Strategies to overcome barriers:
One barrier in implementing the program is the large number of school districts in Bexar County. School districts that are located within the county include: 12 public independent school districts, three districts located within military bases, and a great number of Catholic Diocese Schools, as well as additional private schools and charter schools. The districts vary greatly in size, from as little as three schools, to as many as 95 schools. Additionally, some campuses share nurses or have no nurse at all, as in some private schools.	Face-to-face meetings with each School District Health Coordinator to assess their specific needs. Responsive to requests in a timely manner. Use of personal letters, web page, and E-mail to facilitate communication. Customizing services for specific districts, while at the same time, utilizing resources to share with all the districts.

Role of health department in implementation, planning, and evaluation:

The role of SAMHD is that of facilitator, consultant, educator, and partner to the school district.

Accomplishments:

Celebration during Nurses' Week, which brought together public health and school nurses, and included an educational program. Exhibit at School Nurse Summer Institute. Disbursement of over 7,000 Summer Safety Fliers. Disbursement of a Health Promotion Handout targeting Kindergarten parents for back to school (estimate distribution of 20,000 fliers.

Lessons Learned:

Communication with all divisions of the department is important to allow for coordination of services and information to the school districts. Through personal contact, and listening to the needs as identified by the school nurses, relationships are built, partnerships are enhanced, and ultimately the school population is positively impacted. As partnerships are developed, future projects can be implemented, such as statistical information gathering and policy development. The program challenged us to use creative ways to work with established partners.

Every Woman Every Day

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education Prepare, publish & distribute reports Development of models Newsletters, convening focus groups, advisory committees, networks Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff Training Provide outreach services Identify & report access barriers	Preconception promotion Staff training Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Private source(s): March of Dimes

Budget: Not specified

Description:

In December of 1999, the South Central Texas Chapter of the March of Dimes awarded the San Antonio Metropolitan Health District $10,000 for folic acid education and multivitamin distribution in the clinic and community. The project was titled "Every Woman Every Day." The project involved cooperation among the divisions of Health Education and Promotion, Nursing and WIC. The goal of the project was to increase patients' knowledge that consuming folic acid can help prevent birth defects and to increase the proportion of women who consume 400 mcg. of folic acid daily. The project include surveying professional and paraprofessional staff to assure a strong knowledge base, surveying clients of the clinics in both Spanish and English about their knowledge, attitudes and use of folic acid, providing culturally appropriate print materials to include brochures, reminder magnets and keychains and providing a 90-day supply of multivitamins containing 400 mcg. of folic acid. Additionally, reminder cards were sent out that offered another free 90-day supply of multivitamins.

Objectives of the activity:

1. To provide 2000 women with multivitamins (containing 400 mcg. of folic acid) and education regarding the importance of folic acid in their diet. 2. To survey, in Spanish and English, at least 25% of the 2000 target population on their knowledge, attitudes and behaviors regarding folic acid use. 3. To increase the target population's knowledge that 400 mcg. of folic acid daily can help prevent birth defects and that it should be taken prior to becoming pregnant. 4. To include folic acid education as standard care to women accessing SAMHD clinics.

Barriers encountered in implementation:	Strategies to overcome barriers:
One of the greatest barriers to implementing the project was interdivision coordination and communication. The project required the coordination of three different divisions within the Health District: Health Education and Promotion, WIC and Nursing. The project included 14 different clinic sites. With varying clinic locations, and multiple staff responsibilities, the greatest challenge was working together to implement the project consistently in all the clinics and maintain communication among all groups.	1. Several meetings involving staff and clinic supervisors. 2. Use of E-mail to facilitate communication. 3. Staff meetings and supervisor reinforcement played an important role in overcoming the barriers. The incentives for the clients and the slogan "Every Woman Every Day" kept the staff involved. 4. The value of E-mail cannot be overlooked.

Role of health department in implementation, planning, and evaluation:

The health department and its different divisions were, or will be, involved in every aspect of planning, implementing and evaluating the folic acid project. The department solicited funding from the March of Dimes, and implemented every phase of the project within the clinics. Evaluation of the project will include follow-up surveys to women who were initially surveyed, evaluating the number of packets disseminated and the number of surveys returned. Additionally, once the project is completed a survey will be administered to staff members to evaluate their perceptions of the project and solicit information about how to make this project and similar projects more effective in the future.

Accomplishments:

1. Over 2000 bottles of multivitamins have been dispensed. 2. Nursing, WIC, Health Education have a reinforced effort. 3. Over 300 surveys have been distributed.

Lessons Learned:

1. Interdivision coordination was difficult in implementing this project, but worth the experience for future projects. 2. Buy in from staff members was essential for the project to run smoothly and effectively. 3. Minimizing the work for others, i.e., staff members at the clinic, resulted in missing information. For example, the return of the survey to the Health Education and Promotion Division could not be used as a means to measure the amount of vitamins given out at each clinic as previously thought. Ten of the clinics returned less than 50% of the surveys, and five of those returned less than 10% of the surveys distributed to them. Additionally, in some clinics the vitamin packs remained in boxes long after the project had been underway. The next interdivision project will learn from these lessons and include an increased focus on communication. Overall the project was well received, and efforts to educate women on the importance of folic acid will continue within the clinics of the San Antonio Metropolitan Health District and the community of San Antonio.

Solutions for Improved Youth Health Care

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems Special studies Development of models Promotes compatibile, integrated service system initiatives Provide outreach services Detention settings, foster care, mental health facilities Profiles of provider attitudes, knowledge & practice Identify & report access barriers	Other outreach activities Increasing access to Medicaid Private Health Care Provider Training & Support

Funding Sources:
Private source(s): Collaborators, Other: In-kind Support

Budget: $25,000.00

Description:

After a year-long, private-public collaborative planning effort (including youth themselves), six solutions were identified which are currently moving into implementation. These include a "Provider Toolkit" Solution which is in the design and pilot testing phase. For the "Outreach to Youths and Parents" solution a prospective evaluation study is being designed for up to four strategies to link youth to health insurance and to a primary care provider and to ensure youth have annual comprehensive assessments. For the "Youth/Parent/School Healthcare Coordination" solution, protocols are being developed. For the "Health Referrals after Juvenile Detention" solution, staff will be hired to increase the tracking of youth discharged from juvenile hall who had health problems identified and to link them and other youth on probation to health insurance.

Objectives of the activity:

The underlying Goal is "Improved Health Status of Youth." The particular goals of this initiative are: 1. Primary health care services which are more age appropriate and "youth friendly;" 2. Improved access by youths to health care services; 3. Increased focus on youth by managed care plans.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Explaining why it will be effective to increase linkage to an ongoing relationship with a Primary Care Provider in order to identify and address youth risk behaviors and mental health problems. 2. Providers under capitation are often paid about $5/month to care for youth. 3. The concern if problems are identified—there is a lack of knowledge about resources to address the problems.	1. Education. 2. Toolkit has to have tools to make this limited time as efficient and effective as possible and to utilize other staff/entities in providing the care. 3) Still being discussed with providers.

Role of health department in implementation, planning, and evaluation:

We are coleaders and provide the staff support.

Accomplishments:

Obtained funding for Toolkit design and pilot. Obtained funding for Outreach Pilot design. Staff hired for Juvenile Hall, and part of their job duties included improving discharge planning.

Lessons Learned:

Decisions need to be made collaboratively and certain partners cannot have a greater voice than others, which may not serve the best interests of all collaborators.

Child Care Health Project

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Child Care Community and health and safety training of child care staff	Early intervention/ZERO TO THREE Expanded child health services Injury (including child abuse) Prevention Children with special needs Staff training Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: $400,000.00 This does not include the mental health, PHNs and nutrition consultation

Description:

The overall objective is to improve the health and safety of children in San Francisco child care. Four public health nurses have been hired as health consultants to provide services to targeted child care centers who provide services to a majority of families in the Calworks program (TANF). Centers which have been identified as receiving mental health services are first priority to begin to build a comprehensive team approach. Dental screening, hearing screening, and nutrition consultation is also part of the Health Project model. Health and safety manuals are created for each site: environmental, safety assessment are conducted. Needs assessment have been conducted: Asthma, first aide, and safety training classes have been provided for child care staff.

Objectives of the activity:

1. Assure that every child in the targeted sites have a primary care provider. 2. Improve the ability of child care providers to respond to families' physical and behavioral health needs: Manuals and health training. 3. Ensure that the child care environment is safe of hazards. 4. Identify children with special health needs. 5. Promote appropriate referrals to health and social services. 6. Promote parents' knowledge of appropriate health and dental services.

Barriers encountered in implementation:	Strategies to overcome barriers:
Not having enough funding to respond to the identified needs/requests.	Identification of potential funding sources and applying for grants. Requesting additional county funds.

Role of health department in implementation, planning, and evaluation:

The health department has been the lead agency in the planning, and is implementing the project and will be conducting the evaluation. The project has only been implemented within the last six months.

Accomplishments:

1. Providing services to approximately seven child care centers. Conducting a survey of child care providers to identify what they consider their greatest needs: direct service and health training. 2. Providing training to child care providers in centers and in family day care : asthma, first aid, safety. 3. Collaboration with other health providers, child care administrators, and Head Start, and health training institutes (Schools of Nursing, Medicine).

Lessons Learned:

Working with other systems takes time to completely implement the project. Trust must be created so that other disciplines understand that we want to work as a team in order to improve the health and well-being of the children.

Oral Health Assessment and Surveillance Program

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting Special studies Development of models Provide infrastructure/capacity for MCH functions	Dental programs Building coalitions & partnerships Building MCH data capacity

Funding Sources:
City/County/Local government funds, Other: "Seals on Wheels" a not-for-profit organization providing dental sealants to elemantary school children at school sites

Budget: Not specified

Description:

Using licensed dentists paid by the County, conduct an oral health assessment of 1300 Orange County second, fifth and sixth grade students in elementary schools selected from both low and high income neighborhoods, as well as communities served by optimally fluoridated drinking water and unfluoridated drinking water, to determine the rate of decayed, missing and filled (DMF) teeth. No guarantee of follow-up dental care was offered for participating children.

Objectives of the activity:

The objectives of this activity include: 1.determine the DMF rates among second, fifth and sixth grade students at 40 elementary schools; 2. validate the assessment methodology utilized; 3. establish a baseline DMF rate against which to compare subsequent assessments conducted in future years; 4. determine if DMF rates present among students at low- and high-income schools are significantly different; and 5. determine is DMF rates among students in schools serving neighborhoods with optimally fluoridated drinking water are significantly different from those not fluoridated.

Barriers encountered in implementation:	Strategies to overcome barriers:
Variability of school schedules including traditional and year-round. Heavy academic demands of schools as competition for an oral health assessment. Limited County licensed dentist staff to conduct assessments. Reluctance of teachers to allow classes to participate without some tangible benefit to the children.	Flexible scheduling to accommodate school schedule. When a choice was available, utilized schools in which principal and teachers were interested in oral health issues. Contract with private dentists on an hourly rate to assist in conducting the oral health assessments at schools. To the extent possible, link eligible children participating in the oral health assessment to a community-based dental sealant program.

Role of health department in implementation, planning, and evaluation:

Leadership in the planning, implementation and evaluation of this project came from the local health department. The majority of funding came from the local health department although considerable support came from both the schools and the Seals on Wheels Organization. The evaluation is being performed by the Research and Evaluation Unit of the local health department.

Accomplishments:

Approval from Agency's Institutional Review Board to conduct activity. Securing local funding to underwrite cost of initial and recurring oral health assessments. Gaining cooperation of target elementary schools. Gaining written permission of parents of participating students. Establishing a data baseline for DMF rates in diverse communities within jurisdiction. Developed a local oral health assessment tool and methodology in the absence of known models elsewhere.

Lessons Learned:

Success in obtaining cooperation of school officials in an oral health assessment is improved if students can be ordered follow-up care, such as dental sealants and access to a comprehensive children's dental program.

Maternal, Child and Adolescent Health Professional Resource Faire

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Resource Faire for Health and Human Services Providers	Other outreach activities

Funding Sources:
City/County/Local government funds, MCH block grant funds, Private source, Other: Head Start

Budget: $2,800.00

Description:

The Maternal Child and Adolescent Health Professional "Garden of Resources" Faire was a day for over 350 Health technicians, peer counselor advisors, health educators, community workers, child care, mental health, social work and health care professionals and health care students to network with each other and learn about services available for families in Sonoma County. The Santa Rosa Veteran building looked like a spring festival with pastel balloons and flowers filling the huge auditorium. Providers were literally in a "garden" of resources surrounded by flowers and 80 information tables, with agency representatives giving out information and telling about their services for women, children, adolescents and families. There were also 20 ongoing educational presentations of 15 minutes each given by agencies and programs throughout the event about such topics as domestic violence, childhood safety, Latino fatherhood, children's health insurance, child obesity and teen sexual violence. Mini presentations were listed on the invitational flier mailed out before the faire and was announced on a loud speaker during the event. Event was free of charge, light refreshments were served.

Objectives of the activity:

400-500 health and human services providers will increase their awareness and knowledge of new and exciting programs that work with MCAH population. Health and human services providers will learn new strategies and tools of prevention and intervention to improve the health of families.

Barriers encountered in implementation:	Strategies to overcome barriers:
We had no experience with and were unaware that we needed a fire permit for an event open to the public (providers). It was difficult to convey to health and human service providers that this was an event for professionals and providers only and not open to the general public. Providers felt this event would be a great opportunity for families to learn about services available to them. Providing an environment that was light, cheerful and visually more confined was difficult in a huge auditorium with a high ceiling.	We obtained the fire permit by working directly with the fire inspector that would do the site inspection on the day of the faire. We drew up table and seating diagrams for the auditorium and worked with the fire inspector and building manager to get an approved floor plan prior to the event. We learned that our hand-crafted paper flowers and seed packet decorations needed to be fire proofed, which lead to extra expense and time. We found out that mass produced decorations are fire proofed. We overcame the barrier of faire expectation that the event was open to the general public by carefully wording the

	title for the faire to include the word "professionals." We were careful to list out different categories of providers and professionals that were invited on the invitation fliers and print media advertising the faire. We plan to contact the local Family Expo event and ask them to integrate some resource information on health and human services for families into their annual event to accommodate the request for the general public to be invited to our event. We designed large flower seed packets and bunches of balloons that were hung from the ceiling wires to close in the ceiling space. Flowers with faces of children and teens centered in the petals were hung on the walls. This carried out our garden theme and was cheerful and colorful.

Role of health department in implementation, planning, and evaluation:

The MCAH Program provided the leadership and coordination of the faire. We convened the planning committee which included the local Maternal, Child and Adolescence Advisory Board, Head Start, children's services, perinatal outreach, and human services representatives. We designed an evaluation tool to assess if providers who attended the faire had increased their knowledge and awareness of resources for the MCAH population. Health department staff assisted in planning and putting on the event.

Accomplishments:

Over 350 health and human service providers attended the faire. 91% of the faire attendees that completed the evaluation said that the information tables provided them with a lot of important information about MCAH services.

Lessons Learned:

We learned that it takes a large number of people to set up the event when you have decorations to put up. You need a special setup crew separate from those staffing the faire. Mini presentations were not well attended, because they were in areas away from the information tables. We also think that providers did not have time or were distracted by the information tables to attend the mini presentations. The presentations were going on simultaneously with the information faire. We believe that doing the presentations for only one hour at the lunch time and doing them in the main event area may get better attendance. It was difficult to get accurate attendance because there were several entrances to the faire where providers came in without registering. We learned we needed to restrict the number of entrances or have a registration table at every entrance of the building.

Work First-Public Health Partnership Efforts

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Implement/support education services for special MCH problems Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Home visiting Children with special needs Other outreach activities Increasing social support Case coordination Building coalitions & partnerships

Funding Sources:
Other: Temporary Aid to Needy Families (TANF) Reinvestment Dollars

Budget: $320,000.00

Description:

In partnership with Washington State's TANF program, called WorkFirst, we have developed a program to identify and provide services to WorkFirst participants that are at risk for sanction due to inability to participate in WorkFirst activities. Both DSHS and Public Health have a long history of supporting families in their efforts to attain self-sufficiency. Some families encounter substantial barriers to following through with work. These barriers include issues of substance abuse, mental and physical health, homelessness, children with special needs, and the challenges of caring for young children. Hard to reach families that encounter these and other barriers benefit from receiving intensive public health nurse services in addition to WorkFirst management. We created a contract with DSHS to expand services to hard to serve families that WorkFirst personnel have determined would benefit from additional Public Health Nurse services in King County. These intensive services can include in-home assessments, referrals, parenting education, participation in case staffings, ongoing work with families and coordination with WorkFirst staff in order to connect families with needed community resources and support services that can assist participants in obtaining work and self-sufficiency. These services also include outreach efforts focused on the "hard to serve" WorkFirst clients.

Objectives of the activity:

1. Assess and document factors associated with ability of clients to participate in WorkFirst activities. 2. Develop and maintain the necessary infrastructure for service provision, including collaborative development of policies, training, documentation, and communication of findings. 3. Decrease the number of sanctions due to non-participation in WorkFirst activities. 4. Increase the number of clients able to participate in WorkFirst activities. 5. Increase the knowledge of WorkFirst case managers and social workers about public health nurses as resources to WorkFirst participants who have a child with special needs or other concerns that impact their ability to participate.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. WorkFirst staff turnover and need for an ongoing system of education and marketing of this resource. 2. WorkFirst staff lack of knowledge of available resources for WorkFirst participants. (As former welfare caseworkers struggle to be employment counselors, they have no time to focus on other things.) 3. Different perceptions and difficulties building new working relationships because of past concerns and problems between participants, case managers/social workers, and PHNs. 4. Lack of appropriate child care for all groups and conditions. 5. Expectation of quick outcomes when participants have long term conditions that impact their capabilities. 6. Rigid contracting practices that require payment points associated with outcomes, which does not fit easily with our charting, data collection, and billing systems and make integration with other PH activities very difficult.	Developing ongoing training, outreach (marketing), and support to WorkFirst and Public Health staff. Team building efforts, including collaborative case staffings and providing written reports. Grants have been written to provide funding to train additional staff to work with children with special needs of all ages.

Role of health department in implementation, planning, and evaluation:

We initiated the idea and participated in collaboration with community partners and other agencies serving the WorkFirst population in designing, planning and implementing this effort. These efforts included development of policies, forms, contracts, information packets and joint WorkFirst/PH training sessions across the state. Evaluation includes monitoring numbers and types of referrals using a written survey of Public Health Nurses every two months. This quality improvement process, done by Seattle-King County staff, has identified the ongoing need for training and clarification of system issues.

Accomplishments:

Development of all the policies and the forms for referral, assessment, reporting and billing. Development of a statewide training manual and system for training and support WorkFirst and Public Health staff. Contract signed between Public Health and WorkFirst. Amendment of the initial contract (for parents of children with special needs) to serve a broader MCH population (pregnancy to work, difficult to serve, and those at risk of sanction) and expand the level of service.

Lessons Learned:

Collaborative implementation of a new program requires extensive initial system development, along with buy in from all of the stakeholders. System/Behavior change requires continuous support and information to all participants. Clear, ongoing and consistent communication is critical.

Cross-Cultural Parenting Class

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Bicultural Parenting	Overcoming cultural barriers Building coalitions & partnerships

Funding Sources:
Other: Spokane County Community Network

Budget: $8,000.00

Description:

This is a twelve week course parenting program that educated parents on the social issues surrounding the parenting of biracial and multiracial children. The classes are two hours long and include an open forum discussion, guest speakers and activities that involve both parents and their children. The original grant included a home visit that has since been deleted from the original format. The results of the evaluation indicated that the one-time follow-up home visit was not the same value to the family as the group process. It was decided that the money was better spent in purchasing children's books that gave a positive message to biracial children and to bringing in guest speakers.

Objectives of the activity:

Parents are able to use correct labeling terms for their children. Parents are able to advocate for their children's racial identity as well as teaching their children how to advocate for themselves. Parents are able to identify appropriate children's reading material that does not promote negative stereotypes. Parents are able to take a proactive role in advocating for their children in alternative settings such as schools, neighborhoods, and at family events. Parents are able to identify their own personal biases and how they pass those biases on to their children. Parents have a basic understanding of hair and skin care. Parents have a basic understanding of personal and child safety in light of racial violence and societal ignorance.

Barriers encountered in implementation:	Strategies to overcome barriers:
Personal biases prevent certain cultures from finding the class to be of value. For example, an African American mother of a biracial child would not find the class of value, however a Caucasian or Hispanic mother of a biracial child would enroll. If the topic involved relationships, some fathers would come (Caucasian) but the non-Caucasian would not. A basic understanding of what the classes had to offer and the purpose as well as the topic also created a barrier because it is a very sensitive topic.	After the class was completed, word of mouth by those that took the class and then shared with people they had known that were having similar issues and concerns has generated inquiries and requests to have the classes repeated. It has helped to have the facilitator be a biracial Public Health Nurse who has biracial children because she can relate on a personal level with the class members.

Role of health department in implementation, planning, and evaluation:

The Health District in conjunction with two major community partners: the Transitional Living Center and the Vanessa Behan Crisis Nursery, created a steering committee to develop a biracial parenting class which included key goals and evaluation tools for the curriculum. The Transitional Living Center was responsible for all publicity, the Crisis Nursery employed an evaluator to assess effectiveness, and the Health District supplied a public health nurse to coauthor the curriculum as well as coteach the classes, coordinate community guest speakers, make follow-up home visits with the participants, and implement class scheduling.

Accomplishments:

There is now a completed informal curriculum that is being used, and there is a plan to publish and make it available to purchase to assist others to replicate the class. We are the only agency in the Spokane area that is in a joint venture to offer this type of parenting program to all women that are raising, adopting or fostering biracial and multicultural children. Of the twenty-two families that have completed the course, many have stated that it was very helpful and wish to take the class again, because it helped them deal with very difficult situations involving racism.

Lessons Learned:

It has become evident that there are many families and children that are facing major issues revolving around the topic of societal and familial racism and very few formal resources that are available to them. If the topics are not presented with a significant amount of sensitivity, knowledge and credibility some parents will not only remain isolated but continue to foster dysfunctional beliefs and practices that make it harder on their children to establish their own identity and place in society.

Hmong Baby Steps

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Culturally appropriate health education Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	Family Planning Prenatal care Breastfeeding/nutrition/WIC Immunizations Injury (including child abuse) Violence prevention/at risk Communicable diseases Family Violence Overcoming cultural barriers Increasing social support Increasing access to Medicaid Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, MCH block grant funds, Other: St. Paul Children's Instiative

Budget: $5,000.00

Description:

The Department adapted Baby Steps, a program of the Literacy Council which offers health education to pregnant women and mothers of babies up to one year, to a Hmong population. Health topics are introduced using a children's picture book to address health concerns and parenting, along with modeling the value of reading books with young children. Hmong-speaking paraprofessional staff translated the books into Hmong and provided a Hmong/English version for mothers. The Department partnered with parent educators to deliver two eight-class series in public housing and family resource center settings, with one series targeting hearing-impaired mothers and including an ASL interpreter. Activities included assisting mothers and children to read the book in Hmong, as well as holding a separate educational session in Hmong for the mothers, while an Early Childhood Family Educator worked with the children.

Objectives of the activity:

Provide group education in the Hmong language about women's and children's health and the importance of reading to young children. Demonstrate how mothers who are unable to read English can utilize children's books to promote reading with their children.

Barriers encountered in implementation:	Strategies to overcome barriers:
Saint Paul/Ramsey County has the largest urban Hmong population in the United States. A large number are parents of young children. Many of these parents do not speak or read English, the usual vehicle for teaching health and parenting messages. Opportunities for health and parenting teaching in Hmong are limited. Some mothers are unable to read English or Hmong, so they need help to learn to use the books. Most families have many children, perhaps 3 or 4 under the age of 5 years, so providing enough child care during the classes is a challenge.	Our staff have read the children's books in some of the classes and demonstrated how to use the books and pictures to tell children the story. Our community partners, St. Paul Schools Early Childhood Family Education and Frogtown Family Resource Center, have provided space and child care.

Role of health department in implementation, planning, and evaluation:

The Health Department has partnered with several community groups including the Minnesota Humanities Commission, which offers training to health professionals in the Baby Steps Curriculum. Initially, our English-speaking PHN's taught these classes with the assistance of a Hmong interpreter. Recently 2 of our Hmong Health Education Program Assistants were trained in the curriculum. They now plan and implement these classes in the Hmong language for Hmong mothers and children in collaboration with community agencies, including St. Paul Schools Early Childhood Family Education, Frogtown Family Resource Center, and St. Paul Children's Initiative.

Accomplishments:

In each session, a group of 8-12 non-English speaking mothers and 15-30 of their children are introduced to the importance of reading books and spending time together and receive at least one children's book to take home. The mothers learn about family planning, nutrition, changes in family roles, safety for self and their children and other health topics. Mothers reported learning new information about health and parenting, valued learning the importance of reading (or looking at pictures in) books with their young children, and requested to have additional class sessions.

Lessons Learned:

Participants benefited from the group teaching method instead of home visits only. Mothers unable to read English or their own language (Hmong) valued reading and looking at the pictures in the books with their children, and they appreciated the connection between reading to children and early brain development. Attachment between mothers and children was enhanced by reading the children's books together.

Vasectomy Marketing

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Tracking Systems Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Consistent, coordinated policies across programs Provide infrastructure/capacity for MCH functions Staff Training Provide outreach services Referral systems, resource directories, advertising , enrollment assistance Monitor enrollment practices for ease of use Provide, arrange, administer direct services Prior authorization for out-of-plan specialty services	Overcoming cultural barriers Expanding private sector links Other outreach activities Staff training

Funding Sources:
General state funds, Private source(s): Dr. Douglas G. Stein

Budget: $40,000.00

Description:

1. Distribution of bright red bar coaster with the message "Make my Next one a Vasectomy" and the 462-MALE phone number, to local sports bars. 2. Response to local media inquiries for information about vasectomy and the marketing campaign. 3. Placing small ads in local alternative, throw-away, neighborhood, and ethnic newspapers using nontraditional copy. 4. Establishment of a dedicated phone line with a marketing acronym number (462-MALE). 5. Assignment of a full-time RN to the program for medical assistance, staff and community education and marketing, including direct marketing to health care providers normally providing pediatric and ob/gyn/family planning services to women. 6. Specific marketing materials developed and used: computer mouse pads, coasters, posters, leaflets, temporary tatoos, stickers, and a World Wide Web (www.vasweb.com) touting the vasectomy message in culturally diverse and appropriate languages in the specific communities. 7. Ads in yellow pages—both general and specialized.

Objectives of the activity:

The primary grantor did not require specific measurable objectives. They looked at this program to gather data to assist in establishing baselines for future campaigns. Therefore, the objectives were straightforward and rather simple: 1. Increase demand for vasectomy; 2. Increase public awareness of the procedure; 3. Promote the availability of low cost or no cost services at the local County Health Department. Outcomes related to the objectives set by the grantor are: 1. Increase in number of inquiries for information of 432% in the 7 quarters; 2. Increase in number of vasectomies performed at the PinCHD of 196% during the same period; 3. Increased number of outreach contacts and training/informational sessions by 1219%.

Barriers encountered in implementation:	Strategies to overcome barriers:
Ability to obtain services and materials from non-traditional sources within a large government system.	We have reaffirmed that through consistent and honest communication among all involved in the process, from the creative staff to the compliance staff, new and legal methods of presenting public health issues to the community can occur. Also, there are partners in the community who will assist in efforts ,and they are not bound by government policies and procedures.

Role of health department in implementation, planning, and evaluation:

The Pinellas County Health Department (PinCHD) was made aware of funding availability for a social marketing program for vasectomy promotion. The PinCHD participated in determining type, use, and distribution of marketing materials. Community Education, clinical and administrative staff are involved in planning, data collection, evaluation, and development of ongoing nongrant funded marketing initiatives and materials.

Accomplishments:

1. The marketing campaign was part of the expansion efforts of PinCHD vasectomy services. 2. Clinical staff were trained in how to perform no-scalpel vasectomies. 3. A Board certified urologist became aware of the program as a result of the newspaper story about the marketing campaign and is now assisting in provision of services at PinCHD locations and shares in marketing and promotion of vasectomies as a viable option for family planning. 4. The success of the Program required development and use of standardized practices and procedures, including information packets to anyone calling for information. We expanded in-reach and out-reach programs. 5. Calls to the 462-MALE hotline increased from six per quarter to 262 the seventh quarter. In addition, vasectomies increased from 21 to 119 during the same time period. 6. A procedure manual describing the range of needs, from what materials and supplies were needed for clinics to how to conduct a marketing campaign was developed and completed. It is now available for those interested.

Lessons Learned:

Expansion of awareness of men's health issues with PinCHD staff. Have your product/service ready when the marketing campaign starts. Plan for the future as our campaign resulted in dramatic demand for information and services. There is community interest in vasectomy among those who are not aware of the services, or eligible to receive services due to income at county health department. The public has told us that the anonymous and confidential hotline lets them get information which they cannot access in other parts of the community and frees them from approaching someone who may know them "too well" (e.g., physician, family, friend). Use of humor in marketing makes the topic of vasectomy and other family planning options easier to discuss.

Syracuse Healthy Start Registry

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Implement public MCH Program client data systems	Prenatal care
Community perceptions of health problems/needs	Low birthweight/infant mortality
Tracking Systems	Breastfeeding/nutrition/WIC
Maternal, fetal/infant, child death reviews	Teen parenting
Culturally appropriate health education	Increasing social support
Implement/support education services for special MCH problems	Case coordination
Provide infrastructure/capacity for MCH functions	Staff training
Staff Training	Reshaping urban MCH
Provide outreach services	Building coalitions & partnerships
Referral systems, resource directories, advertising , enrollment assistance	Building MCH data capacity
Identify high-risk/hard-to-reach populations & methods to serve them	Infant/child death review

Funding Sources:
City/County/Local government funds, Other: Federal Healthy Start Grant

Budget: $200,000.00

Description:

Syracuse Healthy Start (SHS) is funded by a four-year Healthy Start II grant awarded from the Health Resources and Services Administration (HRSA). SHS promotes community-based, comprehensive prenatal care and other facilitating services to women, infants and their families, and integrates these services into existing systems of prenatal care. The Syracuse Healthy Start Registry (SHSR) is a population-based computerized monitoring system that began in April 1998 and acts as an active surveillance tool for pregnant and parenting women and their infants through their first year of life. The initial aim of the Registry was to enroll all pregnant women and their newborns living in designated 30-census tract area, but has been expanded to include the entire city of Syracuse. The Registry links with 47 health care and human services providers and community-based agencies to reduce the risk of individuals and families. It promotes healthier pregnancies and positive birth outcomes through risk education, community education, health education and community linkages. All women and their infants, with their consent, are entered into a database, which results in a home visit, social risk assessment, referrals, support, and assistance for identified needs. For postpartum women, family planning is another critical component of this program. Continuous follow-up with receipt of prenatal care and WIC insures that clients actively attend visits for these two essential services.

Objectives of the activity:

1. The four-year project period goal is to reduce the infant mortality rate in the project area by 30%. 2. Reduce LBW in the project area by 20% during the calendar year. 3. Increase first trimester entry into prenatal care to 75%. 4. Adequate prenatal care: Increase to 75% for all women in the project area. 5. Late or no prenatal care: The goal for FY 99/00 was to reduce to 5%, all women in the project area receiving late or no prenatal care. To reduce to 3%, all women in the project area receiving late or no prenatal care. 6. Enrollment of pregnant women in the SHS Registry: 66% of pregnant residents of the project area who delivered infants and 66% of pregnant

residents of the City of Syracuse were enrolled in the SHS Registry during their antenatal period. The project goal is to enroll 90% of all pregnant women. 7. Decrease smoking among Syracuse Healthy Start participants to below 25%. 8. Increase initiation of breastfeeding in the project area and by participants to 50% for the four years. 9. Decrease unintended births to 30% for project period.

Barriers encountered in implementation:	Strategies to overcome barriers:
Creation of an information system responsive to the surveillance needs of the project. Maintain the integrity of the database. In-service training designed to equip Public Health Team members in the accurate collection and entry of data. Registry staff development related to quantitative data analysis and its value for public health on a daily basis. Fragmented data hinders data management and quality assurance. Integration/networking of existing databases with our own agency. Inability to directly access state databases/information systems (Electronic Birth Certificate and Regional Perinatal Data System) for population of and cross-referencing purposes with the Syracuse Healthy Start Registry.	The Registry team consists of an interdisciplinary team, with a maternal child health, public health, and information systems knowledge base. Ongoing database design enhancement continues to be a result of quality assurance and is also responsive to local and federal evaluation objectives. Extensive continuing education of Registry staff members has focused on computer training and basic course work related to using and interpreting data. Issues related to confidentiality continue to be explored. Enhancing tracking capabilities and coordinating outreach services more effectively to positively impact birth outcomes remains as a primary objective of this initiative. Integrating existing information systems within our Health Department remains a challenging task.

Role of health department in implementation, planning, and evaluation:

The role of the Onondaga County Health Department's MCH Public Health Team, Healthy Start staff, Registry staff, and the Health Department's Administrative staff has been one of collaboration in all phases of strategic planning, active involvement in the empowerment of all Consortium and community members, and ongoing and comprehensive evaluation in relation to the effectiveness of evidence-based interventions offered.

Accomplishments:

The infant mortality rate in the project area is less than in the three years prior to the start of the project. The disparity in infant death between African American and Caucasian babies has diminished while the Caucasian rate has also declined. The proportion of low birthweight births has decreased. Adolescent births have significantly decreased during each of the three years of the SHS project. Repeat births to teen mothers are also in decline. The creation and successful implementation of a social risk/public health screening tool and corresponding protocols, consisting of intervention strategies, identify psychosocial risk behaviors. This social risk screening tool is conducted with each consenting woman to identify and assess for an array of risks.

Lessons Learned:

1. The value of collaborative strategic planning within the Health Department and between the Health Department and area providers and community-based agencies. 2. The value of intraagency and interagency resources to create and sustain partnerships that impact the behaviors and health of the community. Focus groups and surveying are very helpful in accomplishing this end. 3. The essential element of evaluation as an ongoing tool in quality improvement activities. Continuous evaluation has resulted in the introduction of new policy and procedures relevant to the interventions and capturing women into care at earlier dates. Evaluation has also encouraged the refinement of data collection for the Registry and improved the tracking and monitoring of project participants. 4. Empowerment of providers, community-based agencies, and community members through personal involvement has been a direct result of this federal funding.

Mobile Public Health Services Program

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Has this activity been formally evaluated?
Don't know

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services	

Funding Sources:
City/County/Local government funds

Budget: $162,500.00 $150,000 for the Program; $12,500 for Sopori Elementary School site

Description:

The Mobile Public Health Services Program consists of two vehicles designed to provide Public health Programs to residents of Pima County—a 35 foot long RV equipped as a clinic and a 15 passenger van equipped as a classroom. The vehicles are used separately and in tandem depending on the location and the needs and interests of the community served. Services provided may vary at each of the locations for the same reasons. At various times, doctors, nurse practitioners, public health nurses and health educators staff the clinic and educational van. The following services are provided at no cost or on a sliding fee scall, depending on the program. Some programs have eligibility requirements for the service or the sliding fee scale. Services: Well Child examinations, vaccinations, health education, school/sports physicals, HIV/AIDS testing and counseling, family planning services, disease outbreak response, disaster response and health screenings and referrals.

Objectives of the activity:

The mission of Mobile Health Services is to provide increased public health programs to Pima County residents, especially where availability to health care is compromised, i.e., areas of Metropolitan Tucson and the greater Metro area that are underserved by health care providers, and where transportation, undocumented status, lack of health insurance and adequate finances are barriers to receiving needed services. Currently services are being provided at 12 locations. Additional outreach efforts occur as needed throughout Pima County. The Mobile Services Program is constantly evaluating additional areas where services may be provided in the future based on need, clinic usage at the various sites by client encounter and by client services provided to determine continuing need for services at that location. In FY 99-00, 5,495 clients were served through Mobile Public Health Services. In May 2000 a site change was made from Sopori Elementary school in Amado to Swetland Community Center in Sahaurita due to dwindling numbers of clients seeking services at the Sopori locations and a community identified need for services at the Swetland Center. During the first 10 months of the FY 99-00, only 38 clients were seen at the Amado site. For the last two months of FY 99-00 15 clients were seen at the Sahaurita site. In the first two months of FY 00-01, 34 clients were seen.

Barriers encountered in implementation:	Strategies to overcome barriers:
1. Lack of transportation to mobile clinic location. 2. Lack of awareness regarding services. 3. Knowledge deficit related to benefits of receiving preventive health services. 4. Fear by undocumented persons that seeking mobile services will put them at risk of deportation by INS.	1. Working with Community Health Advisors and other community agencies to provide transportation for clients in need. 2. posters and fliers were distributed to schools, merchants, and community agencies. Announcements were made at community meetings and in meetings with community leaders. Fliers were distributed door to door at selected locations, and placed in school newsletters. Radio and newspaper coverage was obtained. 3. Ongoing education of the community wherever and whenever an audience of even one person exists to the benefits of preventive health services. 4. Ongoing attempt to gain the trust of undocumented clients who are served to spread the word regarding safeness of seeking services.

Role of health department in implementation, planning, and evaluation:

The Pima County Health Department has been responsible for all aspects of the Mobile Public Health Services Program. The following divisions or programs within the Health Department were all involved: Health Planning & Education, Family Planning, Public Health Nursing, HIV/AIDS Program and Disease Control Program.

Accomplishments:

1. Mobile Public Health Services are presently provided at 12 locations and outreach sites as needed. 2. Services are being provided to many clients who would not have received these services elsewhere. 3. Satisfaction surveys indicate 100% satisfaction with services and would recommend to others.

Lessons Learned:

Need for constant promotion of the program through: 1. PSAs on radio or TV. 2. Articles or announcements in newsletters of schools and community organizations. 3. Mobile clinics and/or educational van present at special events and health fairs.

Partnership KTAK (Keep Tobacco Away from Kids)

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Has this activity been formally evaluated?
Yes

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Culturally appropriate health education Implement/support education services for special MCH problems Development of models	Schools & health connections Building coalitions & partnerships

Funding Sources:
Other: CDC Youth Tobacco Prevention Mini-Grant, Texas Tobacco Prevention Initiative Mini-Grant

Budget: $4,850.00

Description:

Partnership KTAK (Keep Tobacco Away from Kids) is a collaboration of Communities in Schools—McLennan County Youth Collaboration, Inc; American Cancer Society, Brazos Area Health Education Center; Education Service Center, Region 12; Hillcrest Health System; Providence Healthcare Network; Texas Department of Health, Public Health Region 7; and the Waco-McLennan County Public Health District. The Partnership, formed July 27, 1999, has developed a curriculum based on peer education theory using proven materials from leading tobacco prevention agencies. High school students attend training by Partnership KTAK members to receive instruction on teaching the curriculum to fourth grade students in their school district. Once they have completed the training, the high school students will travel to district elementary schools and utilize the interactive materials in all fourth grade classes. The curriculum was piloted and evaluated in two school districts during the 1999-2000 school year. Both participating school districts, Crawford ISD and West ISD, gave the curriculum great reviews, and made suggestions for improvements. Partnership KTAK received two grants this past year to expand services to other McLennan County school districts in the 2000-2001 school year.

Objectives of the activity:

Project Goal: To reduce the use of tobacco products in McLennan County youth by three percent over the next five years. Objective 1: Create and implement a comprehensive, interactive tobacco prevention curriculum in McLennan County. Objective 2: Train approximately 80 students in 16 high schools as peer educators for tobacco prevention. Objective 3: Educate approximately 900 fourth grade students in 16 elementary schools about the dangers of tobacco use through peer education.

Barriers encountered in implementation:	Strategies to overcome barriers:
The greatest barrier experienced by members of Partnership TKAK have been finding the entry point into the schools. Each school has a different system as to how they introduce new curriculum possibilities to their teachers; for some the best entry is through the teachers, for others it is through administrators. The key is getting the information to the high school sponsors as well as the fourth grade teachers, and getting the approval of the superintendent, school principal, and in some cases school counselors.	In order to overcome this barrier, we have utilized our resources at the Region 12 Education Service Center. The Safe and Drug Free Schools coordinator makes the initial contact with the district administrator and the school principal. After getting buy in from the administrators, we make contact with the high school sponsors then the fourth grade teachers. This has been the most successful route for us in making sure that the information gets to the appropriate person in a timely fashion.

Role of health department in implementation, planning, and evaluation:

The Waco-McLennan County Public Health District has played a very active role in all phases of this project. The Health District has organized and hosted almost all Partnership KTAK meetings, helped write and proof the curriculum, trained high school peer educators, purchased supplies and put together tool kits, and contacted schools at various stages of the project.

Accomplishments:

Some of our major accomplishments to date are successful completion of the curriculum in two school districts, securing funding for expansion into 12 McLennan County Schools during the 2000-2001 school year, and commitment from five schools for implementation during the 2000-2001 school year.

Lessons Learned:

The most important lesson learned during this project has been the importance of collaboration. Each organization has made various in-kind contributions. Without many of the in-kind contributions made by each agency, as well as the dedication of each agency, this project could not have been made possible.

Mayor's Newborn Home Visiting Initiative

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Develop tools standardizing data collection, analysis, reporting	Expanding maternity services
Community perceptions of health problems/needs	Home visiting
Environmental Assessments	Breastfeeding/nutrition/WIC
Promotes compatible, integrated service system initiatives	Immunizations
Support of health plans/provider networks	Early intervention/zero to three
Referral systems, resource directories, advertising , enrollment assistance	Children with special needs
Identify high-risk/hard-to-reach populations & methods to serve them	Violence prevention/at risk
Identify alternative resources to expand system capacity	Overcoming cultural barriers
	Increasing access to Medicaid

Funding Sources:
MCH block grant funds

Budget: $710,000.00

Description:

New mothers, parents and guardians responsible for the care of a newborn often need, and want, instructions and support. The newborn home visiting initiative will address this need, ensuring that every family has an opportunity to request a nurse home visit for their newborn shortly after birth. The Nurse will be prepared to make an assessment of the newborn and the house environment; connect the family with available services, including case management; and ensure that needed medical appointments have been made. Office of Maternal and Child Health (OMCH) will provide follow-up services, telephoning the family and the referral agencies/programs to offer assistance.

Objectives of the activity:

1. Distribute a "Welcome Baby" package from the Mayor to District of Columbia mothers upon discharge from all birthing hospitals and centers. The "Welcome Baby" package will incorporate a letter of congratulations from the Mayor and a separate invitation to the birthing mother to call 1-800-MOM-BABY to schedule a nurse home visit. The gift package includes infant clothing imprinted with the theme of the initiative, "Walking You Through Baby's First Days." (quantity=8,000/year) 2. Solidify a referral network between the OMCH Healthline and all existing DC home visiting projects, including those not operated by Department of Health. 3. Provide an initial assessment home visit by a community health nurse to every newborn upon request of the parent. 4. Provide a referral and follow-up for every mother/infant in need of a health care provider and/or support services (case management).

Barriers encountered in implementation:	Strategies to overcome barriers:
1. The time allocated for program planning, implementation, and public launching was three (3) months. 2. No budget line-item to support the initiative was included in the FY 2001 city budget. 3. Existing Office of Maternal and Child Health staff were assigned to program planning and implementation. 4. Hiring of a Nurse Coordinator for the program occurred the day after the public launch.	The implementation plan is founded on creating a network comprising the OMCH Healthline, the nine (9) birthing hospitals, and existing home visiting projects, both public and private. OMCH Management staff developed the program concept, obtained written agreements for all of the hospitals and 80% (4) of the community-based home visiting projects. Each partner has agreed to participate by performing a critical project service. Hospitals will distribute the baskets, home visiting projects will take referrals for follow-up case management and, as resources permit, perform initial home visits. One staff nurse will coordinate the effort.

Role of health department in implementation, planning, and evaluation:

Sole responsibility.

Accomplishments:

1. Agreements with project partners have been negotiated and signed by partners. 2. The project logo (booties) and theme ("Walking You Through Baby's First Days") have been developed. 3. Incentive items have been selected and imprinted with logo and theme (Quantity=8,000 each of baby hats, t-shirts, rattles, booties and mittens, kitchen magnet, Baby Booties" invitation to call for a home visit, and letter from the Mayor). 4. The press conference was held 11/16 resulting in coverage in the *Washington Post*, among others. 5. Packaging in a basket shaped like a pram will be completed 12/15 for the first 1,600 baskets. 6. The Assessment Form and Referral forms have been designed and are in production.

Lessons Learned:

Anything is possible.

Lead Safe Inreach/Outreach Program

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Has this activity been formally evaluated?
No

Has this activity been replicated?
No

Essential MCH Functions:	MCH Initiatives
Environmental Assessments Identify high-risk/hard-to-reach populations & methods to serve them	Lead poisoning prevention

Funding Sources:
City/County/Local government funds, Other Federal funds

Budget: Not specified

Description:

Health Center and Field Services staff working in the high-risk communities were asked to promotte the Lead Safe Program to clients receiving services. Staff explained the program and identified families who may be eligible, and wish to have their home inspected. The purpose of the program is to inspect homes for lead and provide full abatement at no cost to the renter or homeowner in the high-risk community.

Objectives of the activity:

1. To complete 200 LeadSafe applications and home inspections by 7/31/00 2. To complete/perform 60 full abatements by 10/1/00.

Barriers encountered in implementation:	Strategies to overcome barriers:
The initial phase of the HUD Lead Safe Program utilized sanitarians and a contractor to promote the program. This staff made home visits, but very few families were willing to participate. It is our belief that people are suspicious of strangers and those working for the government. Some individuals may have feared repercussions from their landlord.	It was decided to employ another strategy to see if program staff would experience greater success in promoting the program. Health Center and Field Services nursing staff and advocates were asked to promote the program via in-reach. We know that clients are more receptive to information if they receive it from someone they know and trust. Our in-reach strategy involved explaining the program to clients as they waited to be served during their clinic appointments, while being seen by a nurse, nutritionist, or other professional in the clinic, home visit, or community immunization clinic. Staff would also assist clients in completing the application, provide copies of required income or other demographic information, and forward the application and applicable documents to the Environmental Health Division to follow up.

Role of health department in implementation, planning, and evaluation:

To suggest this strategy and compare the results to determine what strategy or combination of strategies produces the most favorable outcomes in the high-risk communities.

Accomplishments:

During the first two weeks of this activity, 344 eligible persons were contacted, and 80 applications were completed. Seventy-five inspections have been scheduled—many of these inspections resulting from applications completed in the health centers. Over 200 inspections have been completed to date.

Lessons Learned:

Be inclusive of other department staff in the implementation of a community-based program. Involve staff who work in the community and those who have established relationships with the persons to be served. Consider the advantages and disadvantages of several strategies.

Partnership for a Healthy Wilmington

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Has this activity been formally evaluated?
No

Has this activity been replicated?
Don't know

Essential MCH Functions:	MCH Initiatives
Community perceptions of health problems/needs Prepare, publish & distribute reports Newsletters, convening focus groups, advisory committees, networks	Building coalitions & partnerships

Funding Sources:
Other Federal funds, Third party reimbursement (Medicaid, insurance)

Budget: $18,000.00

Description:

More than 75 Wilmington community members, leaders, and organizations participated in the Wilmington Enterprise Community (EC) Health Benchmarking Task Force. As evidence of the broad support for coordinated health improvement efforts in the EC, the Task Force drew representatives from local hospitals, public safety, universities, social service organizations, youth groups, community-based health organizations, government, and environmental organizations. Informed by two reports summarizing the health data and the results of the stakeholder interviews, along with their own community and professional experiences, Task Force members approved seven priority areas for health improvement and formed work groups around each. The seven work groups included: 1. Improve Adolescent and Young Adult Health; 2. Improve Older Adult Health; 3. Support Healthy Behaviors; 4. Maximize Access and Use of Health Care; 5. Monitor Wilmington's Health; 6. Create a Health Structure; 7. Environmental Health. As an extension of the Wilmington EC Health Benchmarking Project, the Delaware Division of Public Health (DPH) is continuing to support the collaborative development of a community plan to measure the progress toward improved health in the City of Wilmington. The plan will build upon the work begun in the Wilmington "Health Benchmarking Project" committees, incorporating the ongoing activities of the committees, and other community and city partners working to improve the health of the city. The work groups are encouraged to plan health activities, seek grants for projects and measure progress towards objectives set forth by each committee. It is planned that the city of Wilmington will hold a Health Summit in early 2001 to highlight the activities and the successes of these projects that range from community gardens to pregnancy prevention and youth development activities to walking clubs at senior centers.

Objectives of the activity:

1. Involve the community in identifying the health needs of the City of Wilmington. 2. Develop a community plan to address the identified health needs of the City of Wilmington. 3. Involve the City's Neighborhood Planning Councils in plans to carry out the objectives and activities of each of the work groups. 4. Develop a set of measures to guage progress of the city toward better health. 5. Link the health planning process to the statewide Healthy Delaware 2010 process.

Barriers encountered in implementation:	Strategies to overcome barriers:
Momentum was lost when financial/technical support ended. Political situations change: such as mayoral elections, etc. Community participants were reluctant to take on the responsibility for the health plan development. There was a constant worry about who owned this process, who would pay for the initiatives and who would carry out the work. Politically sensitive issues such as environmental health also caused problems.	Persistence, endurance, constantly bringing the problems back to the forefront, identifying new people to carry the groups forward when others' interests change.

Role of health department in implementation, planning, and evaluation:

Public Health formed the original Steering Committee and guided the Task Force, worked with the PHF as a provider of technical assistance, and now chairs the Steering Committee composed of each of the chairs of the working committees. Public Health funded the technical assistance grant for PHF.

Accomplishments:

Three of the original working groups continue to meet and carry out activities. The Public Health Foundation will have a summary report for the City of Wilmington in September, 2000. The working groups have begun to identify other partners with which to collaborate on grants for health-related activities in the city.

Lessons Learned:

Coalitions and community driven groups are very difficult to maintain and a very resource intensive way to generate work. The rewards are subtle and it takes a long time to see the results.

Infant Mortality Reduction Coalition Plan

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E-mail:

Has this activity been formally evaluated?
Yes

Has this activity been replicated?
Yes

Essential MCH Functions:	MCH Initiatives
Hotlines, print materials, media campaigns Culturally appropriate health education Implement/support education services for special MCH problems Development of models Provide outreach services Transportation & other access-enabling services Referral systems, resource directories, advertising , enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Identify & report access barriers	Preconception promotion Family Planning Prenatal care Expanding maternity services Low birthweight/infant mortality Teen pregnancy Teen parenting Family Violence Overcoming cultural barriers Reducing transportation barriers Expanding private sector links Other outreach activities Increasing social support Strategic planning Building coalitions & partnerships

Funding Sources:
City/County/Local government funds, General state funds, MCH block grant funds, SPRANS funds, Private source(s): Kate B. Reynolds Charitable Trust, Winston-Salem Foundation, 330 funds, Other Federal funds,Third party reimbursement (Medicaid, insurance), Other: March of Dimes, NC Healthy Start, Duke Endowment

Budget: Year 1: $655,850, Year 2: $699,143, Year 3: $734,100

Description:

The Forsyth County Infant Mortality Reduction Coalition provides the leadership to bring together a broad range of individuals; community organizations and institutions to address infant mortality in a coordinated, comprehensive community-based program through a strategic planning process. The Coalition focuses on the development and coordination of programs affecting women of childbearing age, pregnant women, their partners and family members and babies. The coalition will not provide direct services to clients, program participants or consumers. The Coalition developed a Comprehensive Plan, which has received funds for three years. These funds will support the development of neighborhood family resource centers in three targeted low-income neighborhoods: Today's Woman Health and Wellness Center, Mother Wit, Inc. and Living Waters Familiy Resource Center.

Objectives of the activity:

The objective of the plan is to implement programs addressing the multiple layers within our community that effect the problem of infant mortality. We will need to move beyond solely focusing on women's reproductive health issues to lower the infant mortality rate in Forsyth County. We are proposing to implement strategies that have been proven successful in other communities. The emphasis of the plan is social support for making healthy choices, education and about specific behaviors that will reduce infant mortality and improve access to quality health services for women of childbearing age.

Barriers encountered in implementation:	Strategies to overcome barriers:
Two of the Centers included in the Comprehensive Plan did not have the organizational infrastructure to adequately satisfy funders or guarantee they could control large sums of revenue. To accommodate funders the Department of Public Health was required to control all funds. This included hiring of staff for the centers. Many of the staff positions were not traditional health department functions and were required to be classified under the state employment system. The county finance department did not want to pay invoices billed to the centers; therefore legal agreements had to be processed. As it stands now the implementation process is six months behind schedule. The community centers are aggravated at the government policy and delays.	The coalition members are actively participating in lobbying county officials to develop new policy, working with the centers so that they have a better understanding of infrastructure, and providing hands on activities in preparation for implementation.

Role of health department in implementation, planning, and evaluation:

The Department of Public Health provides a Health Planner to coordinate the activities of the Coalition and organizational infrastructure, and supervise the programs and staff in the neighborhood centers. We are also responsible for reporting to the funders and for evaluation of the project.

Accomplishments:

1. Community Health Advocates have been placed at each center with a three-month positive evaluation. 2. An organizational chart and networking agreement has been formalized. 3. Nine new job descriptions have been approved by regional personnel and posted to hire.

Lessons Learned:

Implementation is a longer process if government is involved. Community partners want to move as soon as funding is available. Staff turnover is a problem.

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J-068 Bridging Risk and Opportunity: Highlights of the City**Mat**CH 1996 Urban Maternal and Child Health Leadership Conference

I-106 The Road to Community Partnerships: Highlights of the City**Mat**CH 1995 Urban Maternal and Child Health Leadership Conference

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Lessons Learned 2000

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